BAY-ARENAC BEHAVIORAL HEALTH

Michigan Department of Community Health
Mental Health and Substance Abuse Administration
Improving Practices Infrastructure Development Block Grant
Co-occurring Disorder: Integrated Dual Disorders Treatment
Program Narrative
2007 – 2nd Quarter

1. **MDCH Specialist: Tison Thomas**
   Report Period: 10/1/06 – 12/31/06
   Program Title: Co-Occurring Disorders: Integrated Dual Disorders Treatment
   PCA#: 20700 Contract #: 20071302 Federal ID: 38-3611656

2. **Briefly summarize the Systems Transformation efforts and implementation activities of the Improving Practices Leadership Team (IPLT). Describe the activities and actions taken by the IPLT to improve the overall system of care.**

The Regional Improving Practice Leadership Team (IPLT) met monthly in the second quarter of FY 2007. IPLT members reviewed and approved the IPLT Mission, Vision and Values Statement. The IPLT continues to provide oversight to Regional EBP (and Emerging Practices) activities. The ACT "Field Guide" was discussed. The ACT work group was asked to review and make a recommendation to the IPLT on use of the "Field Guide" for Affiliation ACT teams. The IPLT reviewed first quarter data on Disability Designation, Employment Status and Criminal Justice. Discussion continued on how to best utilize the information for oversight. An intranet site is being developed for team members to access information related IPLT activities. A GANTT chart is being developed to monitor EBP implementation status. The IPLT continues to provide oversight to the COD-IDDT implementation.

3. **Describe the structure within the PIHP and collaborating CMHSPs and CAs that are overseeing the systems change process to support integrated services. Specifically identify leadership team members and state how the leadership team is empowered by the PIHP, CMHSPs, and CAs to oversee the process. What is the level of participation of the CEOs, Medical Directors, and Clinical Directors of each entity? Where does the IPLT fit into the overall structure of the PIHP and CA system, and how is it empowered by system leadership?**

The Integrated Services Work Group and Advisory Council (ISW/AC) is the primary leadership team for development and implementation of integrated services systems change for the Bay-Arenac PIHP, the affiliated CMHSPs and the Riverhaven Coordinating Agency. In addition to the Bay-Arenac

Chairperson/Regional IDDT Coordinator, there is one representative from each CMHSP: Bay-Arenac Behavioral Health, Huron Behavioral Health (HBH is also a contracted Riverhaven SUD provider), Montcalm Center for Behavioral Health, Shiawassee Community Mental Health and Tuscola Behavioral Health Systems. There is also SUD treatment provider representation from: Bridgewater/Bay Human Services, Kairos Healthcare and List Psychological Services. A contracted psycho-social rehab agency (Opportunity Center) is also an active member of the Integrated Services Work Group and Advisory Council.

4. **Has a consensus document been developed regarding the overall system change? How widespread is participation within the PIHP/CA system? Submit any documents regarding consensus development, policy direction, and chartering of quality improvement activities that have been developed. Identify any overall system priorities that have been adopted (e.g., welcoming, screening, data collection, etc.).**

A new Consensus Agreement was developed during the second quarter reporting period. Several revisions were made to the document, and as a result the final draft will not be available until the third quarter. The final draft will be shared with the IPLT and the Affiliation Leadership groups and (if accepted) will be implemented during the third quarter.

5. **Describe participation and involvement during the past quarter of elements of the system that are not part of PIHP/CA service delivery. Include consumer and family stakeholders, primary health care and emergency rooms, criminal justice, homeless services, child welfare, etc.**

As reported previously, this continues to be an underdeveloped area. All current participants are a part of the PIHP/CA delivery system.

6. **Has the system done the CO-FIT 100? If so, describe the process, the score, and what action items are being addressed based on that process? If not, what plans are there to use the tool?**

As indicated in the first quarter report the CO-FIT 100 has been administered twice in the past three years. Each CMHSP partner and participating SUD provider completed the CO-FIT independently with the information then being processed collectively by the ISW/AC to identify systems gaps. With multiple groups completing the CO-FIT, there are issues related to inter-rater reliability, so it was decided the best use of the assessment tool was to use the scores as discussion points for identifying gaps in the system. The ISW/AC agreed with two gaps that were identified by the ISW/AC chairperson/Regional IDDT Coordinator. Gap one related to "Welcoming." It is clear that the current consensus document does not emphasize all aspects defined in this category. The second quarter revision of the Consensus Agreement addressed the "welcoming" issues that was not clearly covered in the original Consensus Agreement. A second item that was identified

and addressed related to "Continuity. Current consumer satisfaction surveys were changed to include measuring "welcoming attitudes." This modification will be introduced during the next scheduled Consumer Satisfaction data collection period.

7. **How widely has the system implemented the COMPASS? How many programs have done the COMPASS, and how many plan to? Describe the process for doing the tool, collecting the results, and assisting programs in creating quality improvement action plans to move toward DDC. What is the status of action plan development and progress for participating programs? What plans are there for widening program participation?**

Each of the five affiliation partners has completed the COMPASS one time. The results of the tool have been used by each to assist in developing their COD-IDDT work plan and/or quality improvement project. The COMPASS will be re-administered during the 3rd quarter. It is anticipated that this second administration will provide some comparative data that will help make the information gathered more useful for Affiliation Partner in developing co-occurring capability.

8. **How has the system organized quality improvement activities related to monitoring improvement in integrated services? What are the targets and indicators? Has this been linked with existing PIHP or CA quality improvement activities? How is it connected with consensus priorities listed in question #4 above?**

As noted in the previous quarterly report, the work of the ISW/AC is not a formally chartered as a QI project. The activities and accomplishments of the work group are monitored on a monthly basis by the AAM affiliation partners Operations Council. This group is made up of the Chief Operating Officers (or their designees) of the affiliation. The BABHA Operations Council representative (Chief of Clinical Operations – Gary Lesley) then reports on ISW/AC activities and accomplishments (and any recommendations from the ISW/AC to the Operations Council) to the Chief Executive Officers of the affiliation at their monthly Leadership Council meeting. Feedback from these councils are provided by the Chief of Clinical Operations to the ISW/AC Chairperson/Regional IDDT Coordinator at bi-weekly supervision meetings. The targets and indicators are found in the Regional COD-IDDT Treatment Work Plan. The work plan is consistent with systems efforts to create a Comprehensive, Continuous, Integrated System of Care (CCISC) that will move the system to a combination of co-occurring capable and co-occurring enhanced service delivery models.

9. **What policies and procedures have been articulated or are in process regarding clinical practice development that is universal in the system: welcoming, screening, assessment, treatment planning, stage matching, integrated billing procedures, etc.? Describe the process of development and submit any products.**

Draft welcoming, screening and assessment policies and/or procedures are being developed for ISW/AC with product expected by the third quarter reporting period.

10. **If you have identified a specific team or teams to implement IDDT, who are they and how were they chosen? Where do they fit in to the larger system's movement toward integrated treatment, and how are they supported by their agencies in this process. Describe how the IDDT teams promote practice improvement in the system as a whole.**

The decision on what teams will implement IDDT will be made by the leadership at each CMHSP partner. Three of the affiliation partners have designated their Assertive Community Team as the IDDT implementation team. The other two are in the process of determining how IDDT will be implemented within their organizations. As the IDDT implementation teams are using the SAMHSA IDDT Toolkit, it is anticipated that experience of the IDDT implementation teams will provide valuable feedback to the system and service levels on the use of the EBP Toolkits for systems change efforts.

11. **What activities are in process regarding IDDT team development? Has the Fidelity Scale been used? Did the PIHP utilize or schedule any Michigan Fidelity Assessment and Support Team (MiFAST) fidelity reviews. What other data collection or performance improvement activities are in process related to the IDDT team? What assistance has been provided by national consultants or others to the team, and what is planned or needed for the coming quarter?**

The Fidelity Scale has been distributed to all affiliation partners for their review. It was anticipated that 1 to 2 Fidelity Assessments would be scheduled during the 2nd Quarter, but changes in the expectations of the MI-FAST team has delayed reviews to the third quarter - at the earliest. The BABH PIHP through AAM Access Center is participated with other PIHP's in a COCE demonstration grant related to access to services. This project involved collecting data on co-occurring and non-co-occurring consumers accessing the service delivery system. Data will be available for review on this project in the third quarter. .

Advanced trainings on Motivational Interviewing/Stages of change (MI/SOC) and MI/SOC Train-the-Trainer events will be held for selected staff during the remainder of the second year of the grant

12. **What activities have been undertaken regarding clinical practice development, both in the system as a whole and for staff in proposed IDDT teams? Have clinicians been widely informed of the process of change and trained in basic principles? Have there been efforts to communicate universal goal of dual competency to all clinicians? Have clinician scopes of practice and core competencies been drafted or are in process? What training efforts have taken place? Has the use of the CODECAT been considered or initiated? If there are clinical training goals (e.g., assessment, treatment planning, motivational interviewing), what policies or procedures are in place to make it likely that clinicians will be organized and expected to begin to use the training in their work?**

Clinical practice development is still in process. Most Affiliation Partners clinicians providing MI Services have been exposed to co-occurring change

capability expectations. The Affiliation Partners are working on paperwork changes that will better "capture" information related to substance use history and a consumers readiness to change. Core clinical co-occurring competencies are being developed by some, but not all Affiliation Partners. The CODECAT has been administered to Access Center staff, but not to other clinical staff Data will be analyzed from the recently completed COCE Access Project along with the Access Staff CODECAT results to develop a comprehensive Access Staff training plan. Implementation of the CODECAT with other clinical areas will be addressed during the 4th quarter of the grant. Polices and procedures will need to be developed to help ensure that clinicians will implement competency skills related to co-occurring capability.

13. What administrative barriers from the state have emerged as issues during the last quarter? What efforts have been made to overcome those barriers? What would be helpful at this point from the state to address those barriers? What else would be helpful for the state to provide or do to facilitate your progress?

No significant barriers from the state were identified during this reporting period.

14. What internal administrative or clinical barriers have you encountered in the last quarter, and what efforts have you made to overcome them? What technical assistance have you received in the past quarter? Are there areas where you feel that you could use specific technical assistance and/or training in the future?

There were no major barriers encountered that required intervention during this reporting period. Technical assistance on Consumer access to services was received from Deb Tate of the COCE. No specific TA is being requested at this time.

15. If the project is having problems with implementation/continuation, will all of the allocated resources be needed? Should an amendment be initiated?

The year to date financial statement is attached. No significant implementation/continuation issues occurred during the reporting period.

16. What are the activities and action plans for the next quarter? Describe how project funding is being used in the coming quarter to support the maximum amount of leverage for practice improvement.

Third quarter focus will include: 1) Completion and approval for implementation of revised "Consensus Agreement" by Regional Leadership. 2) Develop and finalize initial staff co-occurring competencies for implementation in each CMHSP. 3) Develop improved mechanism for identifying and collecting data on persons with COD. 4) Begin development of self directed training modules for improving staff skills related to treating people with co-occurring disorders. 5) All

Affiliation Partners will complete readiness assessment and propose dates for MI-FAST assessment before the end of the calendar year.

17. What actions are being taken by the PIHP to sustain this initiative after the block grant period ends?

Sustainability discussions are ongoing with PIHP Leadership and affiliation partners on strategies to ensure continuation of IDDT efforts after the block grant period ends.

PIHP: Bay-Arenac Behavioral Health
Program Title: Co-Occurring Disorders: Integrated Dual Disorders Treatment
Executive Director: Robert Blackford
Address: 201 Mulholland, Bay City, Michigan 48708

Contact Person: Don MacDonald
Phone:(989) 497-1362 Fax: (989) 497- 1348 E-mail: dmacdonald@babha.org

1. Include the project title, contract number, project number, time period covered, and MDCH Specialist's name at the top of the report. At the bottom of the report, please include the person's name that completed the report, as well as contact information for that person.

Michigan Department of Community Health
Mental Health and Substance Abuse Administration
Improving Practices Infrastructure Development Block Grant
Co-occurring Disorder: Integrated Dual Disorders Treatment
Program Narrative
Quarterly Report

Reporting Period	**01/01/07 – 3/31/07**
PIHP	Community Mental Health Affiliation of Mid-Michigan
Program Title	Adult Mental Health Services
Executive Director & Address	Robert Sheehan 812 E. Jolly Rd Lansing, MI. 48910
Contact Person	Michael Brashears, Psy.D Director: Adult Mental Health Services 517-346-8372 517-346-8370 (Fax) brashear@ceicmh.org
PDA, Contract #, Federal ID	PDA#: 05B1CMHS-03 Contract#: Federal ID #: 38-6337733

2. Briefly summarize the Systems Transformation efforts and implementation activities of the Improving Practices Leadership Team (IPLT). Describe the activities and actions taken by the IPLT to improve the overall system of care.

Systems transformation efforts are evident in the creation of our fifth Evidence Based Practice training that was a collaborative effort between Substance Abuse Services and Adult Mental Health Services. The completion and distribution of a CMHAMM electronic newsletter is an additional systemic transformation effort due to the shared tools, resources, and training efforts between CEI and our four affiliation counties.

Systems Transformation efforts are also evident in our focus on the Organizational Index of the IDDT fidelity scale. This systemic transformation includes program philosophy change that includes CEI and affiliation counties adopting a framework of integrated substance abuse and mental health care in the same setting with the same team. Systems transformation efforts additionally include client eligibility which involves all clients in the services being screened using standardized tools or admission criteria that are consistent with the IDDT.

We are also working toward Penetration defined as the percentage of clients who have access to an EBP as measured against the total number of clients who could benefit from the EBP. This will require major systems change in our evaluative capacity to collect and report this information.

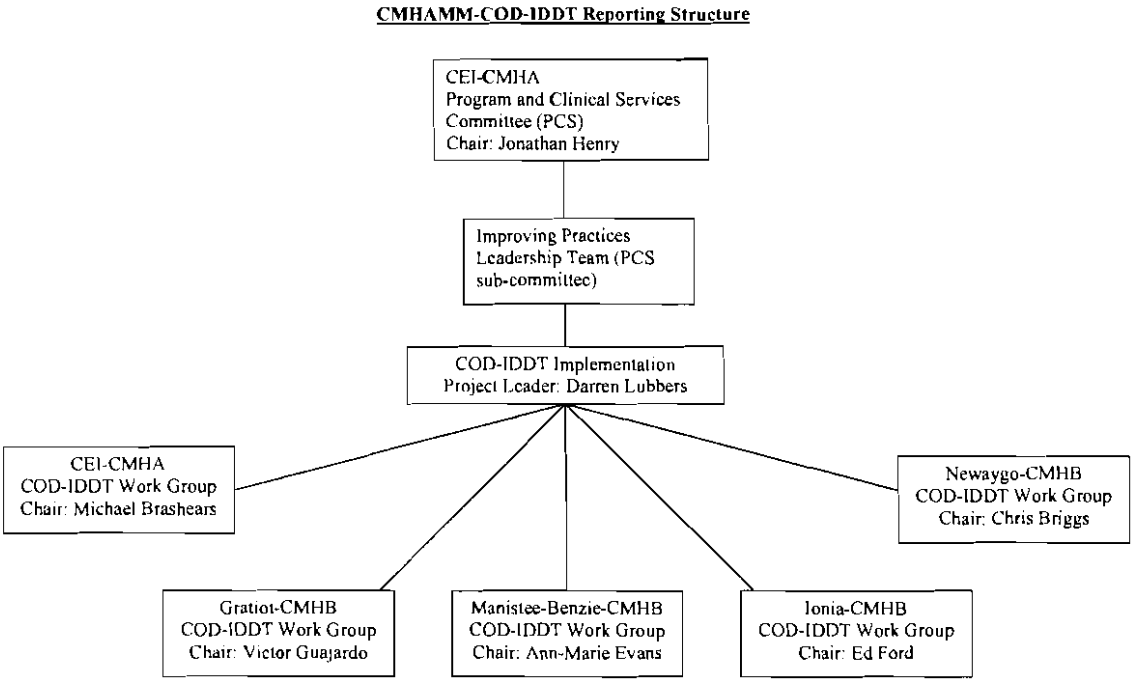
Systemic change efforts that the Practices Leadership Team (IPLT) is additionally working on address Comprehensive assessments which include: history and treatment of medical, psychiatric, and substance use disorders, current stages of all existing disorders, vocational history, any existing support network, and evaluation of biopsychosocial risk factors.

Systemic change efforts additionally addressed include training. We have discussed the future need for all new practitioners receive standardized training in IDDT. We have accomplished this by requiring that all AMHS receive IDDT training however the IDDT fidelity requirement of (at least a 2-day workshop or its equivalent) within 2 months of hiring needs to eventually become CEI policy. CEI existing practitioners have received annual IDDT training (at least 1-day workshop or its equivalent).

Outcome monitoring is another systemic modification that we have discussed during our administration meetings. It has become apparent that the IDDT framework as structured from the current Evidence Based Practice model is not able to specify the particular factors associated with consumer treatment outcomes. We have engaged in a measurement model process

that would statistically evaluate the particular treatment modalities associated with treatment effects.

3. Describe the structure within the PIHP and collaborating CMHSPs and CAs that are overseeing the systems change process to support integrated services. Specifically identify leadership team members and state how the leadership team is empowered by the PIHP, CMHSPs, and CAs to oversee the process. What is the level of participation of the CEOs, Medical Directors, and Clinical Directors of each entity? Where does the IPLT fit into the overall structure of the PIHP and CA system, and how is it empowered by system leadership?



4. Has a consensus document been developed regarding the overall system change? How widespread is participation within the PIHP/CA system? Submit any documents regarding consensus development, policy direction, and chartering of quality improvement activities that have been developed. Identify any overall system priorities that have been adopted (e.g., welcoming, screening, data collection, etc.).

No, a consensus document has not been developed. We are engaged in the IDDT Evidence Based Practice. We have developed a strong positive

relationship with substance abuse services to strengthen our capacity to provide integrated care for our consumers. We are working towards a welcoming integrated system of care that emphasizes screening, data collection, and a unified philosophy that includes integrated substance abuse services and mental health care for our consumers.

5. Describe participation and involvement during the past quarter of elements of the system that are not part of PIHP/CA service delivery. Include consumer and family stakeholders, primary health care and emergency rooms, criminal justice, homeless services, child welfare, etc.

Darren Lubbers PhD conducted a meeting with CEI Emergency Services staff personnel and reviewed the structural and process barriers to the implementation of IDDT. One of the significant barriers to effective emergency services integrated care pertains to the limited availability of appropriate services for individuals that require concurrent detoxification and psychiatric stabilization with appropriate aftercare.

CEI also has a strong jail diversion program that includes clinicians that screen and assess for substance abuse within the jails. The IDDT program will provide the jail diversion clinicians with integrated care alternatives that currently do not exist in an integrated model of care. We have been relying on a parallel treatment system that will be replaced with integrated care with the CEI IDDT transformation. We have also provided significant training to CEI and affiliation staff regarding the importance of family involvement.

6. Has the system done the CO-FIT 100? If so, describe the process, the score, and what action items are being addressed based on that process? If not, what plans are there to use the tool?
7. How widely has the system implemented the COMPASS? How many programs have done the COMPASS, and how many plan to? Describe the process for doing the tool, collecting the results, and assisting programs in creating quality improvement action plans to move toward DDC. What is the status of action plan development and progress for participating programs? What plans are there for widening program participation?

We used the CO-FIT and COMPASS tools approximately a year ago and also implemented these tools several years ago. We have achieved superior results by implementing the IDDT framework due to the specific and measurable factors associated with the IDDT model. The CO-FIT and COMPASS were valuable as discussion tools however they contained subjectivity that was less valuable than the more precise IDDT tools.

ATTACHMENT C – CO-OCCURRING DISORDERS
NARRATIVE REPORTING REQUIREMENTS

8. How has the system organized quality improvement activities related to monitoring improvement in integrated services? What are the targets and indicators? Has this been linked with existing PIHP or CA quality improvement activities? How is it connected with consensus priorities listed in question #4 above?

We are engaging in system organized improvement activities however our staff training process is our initial priority. The focus this quarter from a system change perspective was to create a substance abuse resource guide for the fifth training in the CMHAMM IPLT Evidence based training series. This substance abuse resource guide and training are specifically designed for the skills required to implement IDDT within our settings. This resource guide is based on the previous structure and process analysis of CMHAMM.

9. What policies and procedures have been articulated or are in process regarding clinical practice development that is universal in the system: welcoming, screening, assessment, treatment planning, stage matching, integrated billing procedures, etc.? Describe the process of development and submit any products.

We plan to adjust our policies and procedures after we have completed the staff training that includes a solid understanding of substance abuse counseling, screening, assessment, motivational enhancement and staging.

10. If you have identified a specific team or teams to implement IDDT, who are they and how were they chosen? Where do they fit in to the larger system's movement toward integrated treatment, and how are they supported by their agencies in this process. Describe how the IDDT teams promote practice improvement in the system as a whole.

Yes, we have identified specific programs within CEI and the affiliation that have determined they are working toward high fidelity as measured by the IDDT fidelity scale. Specifically, Eaton county CMH and the ACT team at CEI have determined that they will work toward high fidelity. Manistee CMH has also indicated that they are working toward high fidelity and will engage in a IDDT baseline fidelity review in early May. Newaygo CMH has determined that they will specifically work toward high fidelity with their ACT team. Ionia CMH has also determined that they will work toward fidelity with their ACT team. Gratiot county CMH does not have an ACT team however

they are working toward fidelity with an intensive case management approach.

Although several of the CMHAMM programs have determined that they are working toward high fidelity as measured by the IDDT fidelity scale, the CEI IDDT core leadership has determined that all staff will be trained in IDDT philosophical, organizational, and clinical competencies. In other words, all AMHS staff has attended the Evidence Based Practices training series and will be capable of transferring to IDDT teams or implementing these skills within their teams because of the Evidence Based Practice training series that we have embarked upon. The Evidence Based Practice series includes an Evidence Based Practice overview, Introduction to IDDT training, Motivational Interviewing, Stages of Treatment, and Substance Abuse treatment training. We believe that this important systemic transformation will yield better treatment outcomes across our system.

11. What activities are in process regarding IDDT team development? Has the Fidelity Scale been used? Did the PIHP utilize or schedule any Michigan Fidelity Assessment and Support Team (MiFAST) fidelity reviews. What other data collection or performance improvement activities are in process related to the IDDT team? What assistance has been provided by national consultants or others to the team, and what is planned or needed for the coming quarter?

All CMHAMM staff have received training regarding the IDDT fidelity scale. The CEI IDDT Substance Abuse Resource guide was specifically created to address the substance abuse training needs that are a result of our previous Fidelity scale structure-process-outcome analysis. We observed a definite need for basic substance abuse training within adult mental health services and the affiliation sites that incorporates substance abuse knowledge and counseling in relation to IDDT. The CEI Substance Abuse Resource guide was developed in concurrence with Substance Abuse training sessions for CEI and the affiliation sites. Social worker CEU's will be available for social workers that attend the training.

Darren Lubbers Ph.D. traveled to Manistee this quarter and met with the clinical and management team regarding their IDDT progress. Darren Lubbers Ph.D. assisted the Manistee team with specific planning guidelines for the (Unofficial) IDDT fidelity review and substance abuse training that we have arranged for early May. Darren Lubbers Ph.D. provided the Manistee IDDT team with specific tools, goals, objectives, and questions to prepare for the IDDT fidelity review meeting in May.

12. What activities have been undertaken regarding clinical practice development, both in the system as a whole and for staff in proposed IDDT teams? Have clinicians been widely informed of the process of change and trained in basic principles? Have there been efforts to communicate universal goal of dual competency to all clinicians? Have clinician scopes of practice and core competencies been drafted or are in process? What training efforts have taken place? Has the use of the CODECAT been considered or initiated? If there are clinical training goals (e.g., assessment, treatment planning, motivational interviewing), what policies or procedures are in place to make it likely that clinicians will be organized and expected to begin to use the training in their work?

Darren Lubbers PhD, Rob Davis, PhD, and Barb Starling MSW had a meeting regarding the substance abuse resource guide and three hour staff training regarding substance abuse. This training represents the fifth training in the CEI Evidence Based Practice training series.

The CEI Evidence Based Treatment training series has been as follows.

I. **Introduction to Evidence Based Practices with Michael Brashears Psy.D. as the trainer**
II. **Introduction to Integrated Dual Disorder Treatment (8 sessions conducted) with Darren Lubbers Ph.D. as the trainer**
III. **Motivational Interviewing and Stages of Change I (3 sessions conducted) with Michael Clark MSW as the trainer**
IV. **Motivational Interviewing and Stages of Change II with Michael Clark as the trainer**
V. **Substance Abuse Training (8 sessions scheduled) with Darren Lubbers Ph.D. as the trainer**

The focus this quarter from a system change perspective was to create a substance abuse resource guide for the fifth training in the CMHAMM IPLT Evidence based training series. This substance abuse resource guide and training are specifically designed for the skills required to implement IDDT within our settings. This resource guide is based on the previous structure and process analysis of CMHAMM.

Systems transformation has also been achieved regarding specific programs within CEI and the affiliation that have determined they are working toward high fidelity as measured by the IDDT fidelity scale. Specifically, Eaton county CMH and the ACT team at CEI have determined that they will work toward high fidelity.

Newaygo CMH has determined that they will specifically work toward high fidelity with their ACT team. Ionia CMH has also determined that they will work toward fidelity with their ACT team. Gratiot county CMH does not have an ACT team however they are working toward fidelity with an intensive case management approach. Manistee CMH is working toward high fidelity and will receive a baseline fidelity review training in May.

Affiliation wide activity included (but not limited to) the following activities 1/1/07-3/31/07:

1/12/07 Darren Lubbers Ph.D. conducted a conference call with Manistee regarding IDDT systems and treatment progress.

1/16/07 Darren Lubbers Ph.D. met with Gratiot county Clinical Director and clinical coordinator regarding systems and clinical change progress regarding the implementation and next steps for IDDT within Gratiot county

1/26/07 Darren Lubbers Ph.D. attended the MIFAST meeting in Lansing.

1/29/07 Darren Lubbers Ph.D. attended the MDCH measurement and evaluation meeting in Lansing.

1/30/07 Darren Lubbers PhD attended the MDCH IDDT EBP subcommittee meeting

1/30/07 Michael Brashears Psy.D., Darren Lubbers Ph.D. Judi Cates MA (CEI substance abuse director) and several affiliation project leaders, clinicians, and case managers attended the MDCH Learn and Share meeting

2/1/07 Darren Lubbers, Ph.D. met with Michael Brashears Psy.D. and discussed systemic, organizational, and clinical IDDT progress regarding affiliation and CEI teams.

2/6/07 Darren Lubbers Ph.D. met with Julie Dowling and the management team from Ionia regarding IDDT progress. It was determined that the Ionia affiliation will begin to focus their IDDT efforts specifically within the ACT team.

2/8/07 CEI IDDT core leadership group met and discussed the substance abuse training for all adult mental health services staff and the IDDT substance abuse resource guide.

2/13/07 CEI Integrated Treatment for Dual Disorders Effective Practice book review meeting.

3/9/07 Darren Lubbers PhD traveled to Manistee and met with the clinical and management team regarding their IDDT progress. Darren Lubbers Ph.D.

assisted the Manistee team with specific planning guidelines for the (Unofficial) IDDT fidelity review and substance abuse training that we have arranged for early May. Darren Lubbers PhD provided the Manistee IDDT team with specific tools, goals, objectives, and questions to prepare for the IDDT fidelity review meeting in May.

3/13/07 CEI Integrated Treatment for Dual Disorders Effective Practice book review meeting.

3/13/07 CEI IDDT core leadership group met and discussed the substance abuse training for all adult mental health services staff and the IDDT substance abuse resource guide The meeting also reviewed planning and implementation of IDDT within CEI. The specific teams that will be achieving IDDT high fidelity as measured by the IDDT fidelity scale were discussed.

3/22/07 Darren Lubbers PhD met with the Ionia ACT team and reviewed the IDDT model and how to apply the model.

3/23/07 CEI conducted a Motivational Interviewing meeting for all of the staff that attended both Motivational Interviewing training I and II. This meeting reviewed important implementation issues within each program and team.

3/27/07 Darren Lubbers PhD met with the Gratiot clinical team and administrators regarding IDDT implantation progress.

3/30/07 CEI conducted a second Motivational Interviewing meeting for all of the staff that attended both Motivational Interviewing training I and II. This meeting reviewed important implementation issues within each program and team.

13. What administrative barriers from the state have emerged as issues during the last quarter? What efforts have been made to overcome those barriers? What would be helpful at this point from the state to address those barriers? What else would be helpful for the state to provide or do to facilitate your progress?

    The primary concern indicated by administrators pertains to the certainty of being able to receive reimbursement for integrated services. Although cost savings for IDDT programs will become evident with reduced costs because of integrated care for quadrant IV consumers, administrators have indicated concern regarding the enhanced cost of providing these services. A clear message from the State regarding the HH modifier system will be helpful.

ATTACHMENT C – CO-OCCURRING DISORDERS
NARRATIVE REPORTING REQUIREMENTS

14. What internal administrative or clinical barriers have you encountered in the last quarter, and what efforts have you made to overcome them? What technical assistance have you received in the past quarter? Are there areas where you feel that you could use specific technical assistance and/or training in the future?

We have internal technical assistance available and therefore developed much of our own training materials. CMHAMM has internal substance abuse experts that are able to provide technical assistance and we have hired experts such as Michael Clark MSW for training needs that include Motivational Interviewing and Stages of Change. Darren Lubbers Ph.D. has doctoral level substance abuse training and has worked for substance abuse services in residential treatment settings and in the jails. Darren Lubbers Ph.D. has also traveled to Ohio numerous times to learn from the Ohio SAMI CCOE team. He has also observed fidelity reviews with the Ohio SAMI team. The CEI team has worked in collaboration with substance abuse services to create training and a resource guide to enhance substance abuse services within CMHAMM.

15. If the project is having problems with implementation/continuation, will all of the allocated resources be needed? Should an amendment be initiated?

CMHAMM will require continuation funds to begin the implementation phase of our IDDT transformation. We have accomplished significant steps forward with structure-process-outcome analysis of our seven counties and we have accomplished significant staff training across all counties and we have included all staff in our trainings. We will need additional continuation funds to transform specific teams into high fidelity IDDT teams as well as the organizational and systemic modification that have been successfully started at CMHAMM.

16. What are the activities and action plans for the next quarter? Describe how project funding is being used in the coming quarter to support the maximum amount of leverage for practice improvement.

The next quarter will specifically involve the fifth training in our Evidence Based Practice training series. This training will be a substance abuse training that will teach staff the genetics, neurobiology, and clinical skills that are critical basics related to substance abuse case management and counseling. They include classical conditioning, operant conditioning, social cognitive leaning theory and cognitive behavioral theory as it relates to

substance abuse. All CMHAMM participants will receive a copy of the substance abuse resource guide that was a coordinated effort between Adult Mental services and Substance Abuse Services.

The next quarter will also involve a 1.5 day IDDT Fidelity Baseline review for Manistee CMH.

17. What actions are being taken by the PIHP to sustain this initiative after the block grant period ends?

We hope to receive continuation funds and continue to employ Darren Lubbers Ph.D. as the IDDT program leader as well as hire physician consultants that will provide technical assistance for our psychiatrists.

Michigan Department of Community Health
Mental Health and Substance Abuse Services Administration
Improving Practices Infrastructure Development Grant
Co-occurring Disorder: Integrated Dual Disorders Treatment
Program Narrative
Quarterly Report

Report Period: January 1 – March 30, 2007
PIHP: Kalamazoo CMHSAS dba Southwest Michigan Urban and Rural Consortium (KCMHSAS)
Program Title: Integrated Dual Disorder Treatment (IDDT)
PCA#: 20705 **Contract #:** 20071300 **Federal ID:** 38-3313413
MDCH Specialist: Tison Thomas

The Southwest Michigan Urban and Rural Consortium of Allegan, Cass, Kalamazoo, and St. Joseph Counties is committed to aggressively transforming our system of administration and care delivery to one focused on the expectation of co-occurring disorders (CODs), effective and efficient consumer identification and referral, and the full implementation of models of care including Integrated Dual Disorder Treatment (IDDT) in high fidelity programs for the most vulnerable consumers. The Affiliate continues to focus on assuring that all services within the PIHP are Dual Disorder Capable, while at the same time moving forward with IDDT readiness and implementation in several settings throughout the PIHP.

1. **System Transformation/Improving Practices Leadership Team Efforts**

- Combined previously separate Clinical/Evidence Based Practice Team and IDDT/PMTO/FPE Steering Team into a single committee, the Improving Practices Leadership Team, with meetings on a bi-monthly basis (see updated roster); added newly appointed Chief Information Officer, Rob Moerland, to committee
- Completed system's transformation consultation with Dr. Chris Cline 3/22/2007, who recommended separation of IDDT readiness and implementation services from system's change process, and placement of system's change process team in role well above IDDT implementation to impact system-wide change needs. Concept of System Transformation/Best Practices team make-up, mission, and vision to Exec. Director for comment

2. **System's Change PIHP structure**

- 2 Executive Directors, 3 Clinical Directors, and RCA Director participated in consultation with Dr. Cline. Clinical Directors throughout PIHP provide regular representation to the IPLT, and minutes, as well as quarterly reports are available to Executive Directors
- COD/IDDT workplan placed into Strategic Planning format, and presented to PIHP Affiliate CEO/CFO group in February
- Medical Director, Dr. Gopal Bedi, providing leadership in several key change process areas: 1) consultation with Dr. Cline, 2) assuring medical staff all receive physician-specific training on CODs (scheduled 4/12 with Dr. David Mee-Lee, as well as on-going with COD/IDDT Coordinator modules during med staff meetings every 2 months) and Suboxone competencies (4/12 following Dr. Mee-Lee training).

3. **Consensus/Charter Document**

- Based upon consultation recommendations by Dr. Chris Cline, the previous Charter of the PIHP has been placed into a policy format, and adopted as an official policy statement of the PIHP (see attached Policy 35.15 – in approval process)

- Since Dual Disorder Capability is set as a system-wide baseline expectation for all service providers, characteristics of DDC have been developed as a starting place for discussions with MI and SUD providers, to gain consensus and establish incentives/disincentives for achievement of DDC
    - Complete an agency-wide or program-specific COD self- assessment tool (COMPASS or CO-FIT) every 18 months to mark progress
    - Develop an agency action plan with 2-3 projects based upon COMPASS/CO-FIT results to improve capacity with COD services, and report to fellow agencies and KCMHSAS on success and updates annually
    - Develop a training plan for staff to enhance COD services, and report on success and updates annually.
    - Provide agency representation to Kalamazoo COD/IDDT Agency Steering Team and/or IDDT Program Workgroup (latter if implementing IDDT as an evidence-based practice) monthly

4. Participation of parties not part of the PIHP/CA

- Peers continue to play an important role in the IPLT and IDDT Workgroup, and work as part of the block grant implementation
- Ministry with Community (homeless day shelter) social worker serves on COD/IDDT Agency Steering team along with MI/SUD providers
- COD:IDDT Coordinator and Peer Support Specialist active members of Michigan Prisoner Return Initiative (MPRI) transition team to provide services to inmates returning to the Kalamazoo community, and the Jail Diversion task force for Kalamazoo County

5. CO-FIT 100 Completion

- The PIHP completed the CO-FIT in July of 2006 in the IDDT Workgroup, and based upon results developed two Performance Improvement Teams (PIT) to address areas of concern over repeat administrations
- Expanding the housing continuum for consumers with COD was identified for Kalamazoo, and COD representatives were invited to join and expand the Housing Consortium, which occurred
- Universal screening for COD was identified as the second PIT, which was addressed through participation in the COCE Technical Assistance team in collaboration with 5 other PIHPs resulting in: 1) piloting of a screening tool (UNCOPE), 2) notation of prevalence of COD, 3) stage of change for MI and SUD at assessment, and 4) inclusion of the ASAM/LOCUS criteria in identifying disposition.

6. COMPASS Completion

- Ten COMPASS program evaluations were self-administered throughout the PIHP in May – June 2006
- Since only one COD/SUD provider completed the COMPASS, there are plans in the third quarter to present not only the steps to DDC to SUD and MI providers, but to provide necessary technical assistance specifically to SUD providers to complete system evaluation tools

7. Quality Improvement Activities

- COD Quality Improvement activities were coordinated with other organizational QI projects in anticipation of MDCH and CARF reviews in April/May 2006
- Specific attention was placed on system-wide QI projects to provide universal screening and make assessment comprehensive to assess single or multiple consumer presenting concerns as assessment

- Contracts in development with all providers will make similar provider competency and licensure expectations whether providing MI, SUD, or COD services

8. Policies and Procedures Developed

- Policy 35.15 Co-Occurring Psychiatric and Substance Use Disorder Services developed based upon recommendations of Dr. Cline, and forwarded to PIHP UM for approval
- Policy 40.01 Assessment of Substance Use Disorders, Mental Illness, or Co-Occurring Disorders updated and forwarded to PIHP UM for approval (see attached)

9. **IDDT Implemeutation Teams**

- Two teams within the PIHP have self-selected to implement IDDT: InterAct ACT Team 3 is in it's fourth month of pilot implementation with 12 voluntary consumers already served on the ACT Team who agreed to participate in IDDT. IDDT Team members were invited to partieipate in the pilot, but did not have to in order to remain on the team. Sinee the baseline Fidelity Scale was used on a different team at this agency, an updated Fidelity Readiness consultation was completed on 3/15/2007 with Deb Myers, Steve Wiland, Stephanie Lagalo, Nancy MacDonald, and Jennifer Harrison, and is awaiting report
- The second team which has elected to implement IDDT is St. Joseph CMH ACT team. Components of the model are in place, and all ACT team members have agreed to participate in piloting IDDT with the approximately 15 of 23 consumers currently served by ACT who have a co-occurring SUD. A Readiness Fidelity consultation was completed on 4/2/2007 with Deb Myers, Tammie Glenn, Doug Lockwood, Vicky Merrills, and Jennifer Harrison to determine readiness for Fidelity Baseline by MiFAST team.

10. IDDT Team Development

- In addition to the two team where are in the implementation process, two additional teams have identified an interest and desire for more training and consultation regarding IDDT
- Douglass Community Association Targeted Case Management (TCM) team has identified 10 potential consumers who may benefit from IDDT, and have asked COD/IDDT Coordinator to provide consultation during staff meetings specific to staging consumers, and providing interventions specific to stage of treatment
- Woodlands Behavioral Health TCM team is in preparation to implement portions of the IDDT model as they offer Dual Disorder Enhanced services within their integrated team. Training from COD:IDDT Coordinator will kick-off this project on 4/12/2007
- The Ohio SAMI CCOE and MiFAST Lead Reviewers have provided eonsultation on specific incremental steps toward implementation and enhanced fidelity of the implemented teams

11. **Clinical Practice Development**

- Dual Disorder Capability across the PIHP is now well understood by CMHSPs, but less clear to provider organizations; informational and consensus-building meetings will be held within the next quarter with provider directors and KCMHSAS Board members
- Training efforts have taken place with non-clinical staff (administrative, finanee, quality, support staff) related to basic principles of COD, prevalence and incidence, clinical outcomes, the national consensus 4 quadrant model, DDC and DDE programs, and IDDT as an EBP on 3/1/2007, with additional similar trainings available to CMHSP or provider administrative staff; additional trainings across the PIHP (direct staff and providers) in Welcoming and Engagement Strategies were completed on 2/26/2007 and 2/28/2007 for information and referral and support staff
- Trainings for clinical staff have focused on agency-requested topics meeting the needs of their training plans: Access staff training on staging consumers, use of the UNCOPE, welcoming strategies, and ASAM criteria was completed on 1/31 in anticipation of the COCE pilot project; trainings in SUD Abuse and Dependence was completed for all staff at Senior Services; training

on SUD Treatment and Stage-Matched Interventions was completed for Macomb CMH on 3/15/2007

- The CODECAT has not yet been administered, with no current plans to implement currently until further into the change process

12. State Administrative Barriers

- Requiring by contract the Substance Abuse Licensing AND Accreditation by a national accredited board to become a SUD provider: Accreditation by single or small practices who offer SUD or COD OP services is cost prohibitive, and limits our provider panel to exclusively large, agency-level providers. The Regional Coordinating Agency has considered an application for a waiver from the contract requirements regarding this, and has consulted with Doris Gellert, who reports the ODCP Workforce Development group is addressing this issue in the future
- Lack of clarity about ways to credential, report, and bill for Peer Recovery Services specifically when offered an integrated service by certified Peer Support Specialists. Currently awaiting technical advisory on Peer Recovery services licensure category

13. Internal System Barriers

- Placement of IDDT Program workgroup relative to achieving significant system's change
- Engagement of SUD providers in change effort which has been primarily focused on IDDT implementation
- Coping with relapse or symptom increase of staff involved in co-occurring initiatives who themselves are in recovery

14. Resource Utilization

- The grant requirements have been successfully met to date with every anticipation that that trend will continue; grant funds will be fully utilized in this FY

15. Next Quarter Activities

- Informational and consensus-building meeting with MI and SUD provider directors toward Dual Disorder Capability steps
- Training for Woodlands, Allegan CMH on stage-matched treatment, InterAct intensive team training in IDDT, Family and Children's Services on identification of SUDs in adolescents
- Certification of KCMHSAS medical staff as Suboxone prescribers
- Fidelity baseline review for St. Joe CMH, and readiness consultation for Douglass Community Services
- COCE Technical Assistance site visit 4/24 and 25
- Motivational Interviewing phase I training for agency leaders May 1

16. Sustainability

- Discussions are ongoing about both continuation of IDDT as an EPB sustainability, and well as COD systems integration efforts

Milestones Achieved

- 7 self-identified COD peers now certified as Peer Support Specialists in Michigan
- Key role in efforts to provide added services to MiFAST team to allow consultation and technical assistance as follow-on services to fidelity assessment within Michigan
- Following receipt of MDCH Block Grant for Recovery Shoppe/Recovery Enterprises/Recovery Institute, applied for additional funding for space costs, "Getting to Work" apprenticeship stipends, public transportation passes for newly employed consumers with SMI at Ministry with Community, and 2 additional PSS staff to be part of Recovery Team to Kalamazoo Community Foundation and Fetzer Foundation
- Sharing of training and consultation resource with adjacent PIHP, Venture Behavioral Health, including joint piloting of UNCOPE screening measure for adults and adolescents being assessed for mental health condition
- Increased resources and availability of a COD:IDDT resource library for use throughout the PIHP, and forwarded to MDCH for use throughout the state

Consensus Building

- Consensus of KCMHSAS medical staff about 1) utilization of Client Benzodiazepine Agreement, 2) piloting of DALI-14 in medication clinic for all new consumers (starting Feb 1, 2007), and 3) training and registration of KCMHSAS medical staff to be Suboxone providers (by March 31, 2007). Also shared training resources from Dr. Christina de los Reycs with several additional medical staff planning to attend Spring training in West Michigan
- Consensus regarding central service population of Recovery Institute and other peer-to-peer recovery initiatives being available to consumers regardless of presenting or multiple illnesses
- Consensus with Access staff supervisors re: implementation plan for COCE demonstration site project, including persons responsible and how IT and training will be utilized in project

Utilization of Systems Assessments Update

- Finalization of initial performance improvement projects based upon CO-FIT results over two administrations
- Use of IDDT Readiness assessment with use of Deb Myers of Ohio SAMI CCOE to consult with Stephanie Lagalo of InterAct re: fidelity baseline follow-up steps for InterAct IDDT workteam
- Based upon PIT projects, participation of IDDT Coordinator in local Housing Resources team to determine more effective menu of housing options for consumers with COD at various stages of readiness

Training and Technical Assistance

- Technical assistance calls with Deb Myers and Stephanie Lagalo as part of GLATTC Leadership Institute
- Training for PIHP (also invited staff from Network 180 and Venture) re: Introduction to IDDT and COD treatment in group and family settings. 135 attending October 19th training, 63 attended November 14th
- Team Leaders from each county in PIHP (from two provider organizations in Kalamazoo) attended IDDT Program Leader training with Ric Kruzeski and Patrick Boyle December 5, 6
- One physician and IDDT Coordinator attended Dr. Christina de los Reyes IDDT Physician training in Ann Arbor November 28
- SW PIHP facilitated Learn and Share October 22

Barriers to Implementation

- Lapse in Allegan ACT Team Leader from May - October 2006 (Karen Feaster hired October 2006)
- Information system's dissimilarities (Carenet and CMS). New integrated system in development with plans to launch Phase 1 October 2007; until then changing current programming is difficult and cost prohibitive
- Visibility of Certified Peer Support Specialists in Kalamazoo; they are so extraordinary that they are in tremendous demand to provide assistance to other systems; this makes peer efforts in SW Michigan difficult to maintain consistently

Implementing Enhanced Service Model

- Baseline fidelity assessment completion by InterAct of Michigan on SAMM team July 2006. Based upon findings, recommendation approved to implement IDDT on ACT Team 3 at InterAct effective November 1, 2006. Changes made to process of authorization and assessments for SAMM so that program can continue to be a Dual Disorder Enhanced (DDE) program for Quadrant III (high SUD, low MI) consumers. InterAct IDDT workteam completing crosstraining of stage-matched group offerings, and forms transition to include requisite portions of IDDT EBP.
- Douglass Community Association identified IDDT team leader Jeanette Bayyepuneedi, LMSW as primary contact.
- Allegan ACT focused on preparation for IDDT by training team leader Karen Feaster in model; and Woodlands (Cass) Kathy Boes and Steve Lehman determining portions of IDDT that can be implemented in rural county

Financial Support and Sustainability Planning

- Substance Abuse PA2 funding continues to be available this FY as a non-required local match to support IDDT and system transformation activities
- Discussions regarding assuring system change and EBP implementation following grant period end on-going
- Plans to re-submit SAMHSA Peer-to-Peer Recovery Community Services grant application to provide funding for a peer recovery agency to serve individuals with single or dual disorders in Kalamazoo

Next Quarter Activities

- Participation of increased PSS in Learn and Share Activities from Kalamazoo (5 planning to attend January session)
- Determination of availability of peer-to-peer recovery federal grants for reapplication
- Training
- On-going twice monthly "mini-training" and supervision of Access, Mobile Crisis and Response Team (MCIT), Emergency Mental Health (EMH) clinicians, and Information and Referral staff on COD screening, utilization of welcoming principles, motivational enhancement strategies, and consumer staging
- Planned integration of Welcoming training to non-clinical Access staff throughout PIHP including provider support staff
- Development of integrated assessment format to be programmed into Carelink system with components of Integrated Longitudinal Strength-based Assessment (ILSA) (narrative format, most recent stable baseline, and stage of readiness and goals per presenting concern) and current assessment format (required fields, eligibility, demographics, releases for care coordination)
- COD Introduction training to Finance, IS, Quality, and Support Staff PIHP groups in collaboration with consultant Mary Dengerink

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
MENTAL HEALTH AND SUBSTANCE ABUSE ADMINISTRATION

CO-OCCURRING DISORDERS (IDDT)
PROGRAM NARRATIVE
FY 2006/07 2nd QUARTER REPORT

1. Report Period: 1/1/2007 – 3/31/2007
PIHP: LifeWays
Program Title: CO-OCCURRING DISORDERS PROJECT
PCA#: 06B1MICMHS-03 Contract #: 20061242 Federal ID: 38-2056235

MDCH Specialist: Tison Thomas

2. **Systems Transformation Efforts and Implementation Activities of the Improving Practices Leadership Team (IPLT):**

The IPLT continues to meet for 1.5 hours on a monthly basis to review the organization's progress on the EBPs of FPE, IDDT, MST, and the Medication Algorithm project. The membership includes representation across the continuum of care for the MI Adults, SED children, and individuals with Developmental Disabilities. The membership also includes the Coordinating Agency (Mid South)-however they have yet to attend, consumers and parents. New members replaced old members 2/1/07 due to the following personnel changes: IPLT leader and EBP coordinator left the agency and the Finance and Data Director received a promotion. (see attached revised membership listing).

In February 2007, the Coordinating Agency (Mid-South) supported the attendance and IPLT membership of one of its leaders. Although this leader from Mid-South is excited about participating, she will not be able to attend meetings until May or June due to begin on Medical Leave.

In February 2007, the IPLT Leader had a 2 hour phone conference call with Tison Thomas, MDCH Specialist for IDDT. This phone call provided an overview to COD system transformation and the IDDT program and how these items fit together. System transformation resources were also provided.

In March 2007 an expanded role of the IPLT was implemented. The IPLT's role was expanded to include an analysis of the effectiveness of the services offered across LifeWays Continuum of Care for each population (MI Adult, SED Child, and DD). For this reason, 3 subcommittees representing each of the population groups have been defined and established. The "leaders"/"chairs" of these subcommittees will be the IPLT members representing the specific population. The subcommittees will include representation from all of LifeWays Service Provider Network, parents, consumers, and community organizations/systems.

Based upon their analysis of LifeWays current service array and continuum of care, the subcommittee will make recommendations for system of care enhancements to the IPLT. In turn, the subcommittee leaders and IPLT leader will present the recommendations to LifeWays leadership and Board of Directors. The IPLT bylaws will be revised to include this expanded role. These subcommittee members will become active advocates and system leaders in improving the recovery culture across the LifeWays Network, in encouraging the paradigm shift in the treatment of individuals with co-occurring disorders, and improving the children's system of care.

In March 2007, a document describing EBPs, how programs become EBPs and the status of research based programs within the LifeWays Provider Network was created, presented, discussed and distributed to the IPLT members to use in further educating staff within the LifeWays Service Provider Network, LifeWays Leadership and Board of Directors and the community at large. The document is scheduled to be presented at the LifeWays Service Provider Meeting and LifeWays Board of Directors in April 2007. The IPLT members will use this document to further educate their staff on EBPs.

In March 2007, the COO of Mid-South and the Director of their contracted CDRS met with the IPLT Leader and LifeWays Access Center Director to discuss the development of an integrated COD access point. Mid South and the CDRS Director also agreed to join the IPLT Leader and LifeWays Access Center Director in meeting with Network 180 on how they have transformed their "front door". Mid South coming to the table and agreeing to be a part of the co-occurring disorders system transformation is a significant step.

In March 2007, the IPLT Leader participated in a 2 hour phone conference with Genesee CMH regarding the implementation of MST. The Genesee Leader explained their development of the community system of care team to support the implementation of the MST program.

Due to some of the IPLT members' interest in becoming IDDT providers and MST providers, the IPLT members who are Service Providers can not participate in the development of the MST and IDDT RFPs or discussions with Network 180 about IDDT or Genesee CMH about MST. The IPLT leader is sharing general overview statements about the system transformation meetings that are being held.

3. **Describe the structure within the PIHP and collaborating CMHSPs and CAs that are overseeing the systems change process to support integrated services. Specifically identify leadership team members and state how the leadership team is empowered by the PIHP, CMHSPs, and CAs to oversee the process. What is the level of participation of the CEOs, Medical Directors, and Clinical Directors of each entity? Where does the IPLT fit**

into the overall structure of the PIHP and CA system, and how is it empowered by system leadership?

LifeWays is the PIHP/CMHSP that is responsible for Hillsdale and Jackson Counties. It is a "stand alone" PIHP with no alliance or "hub and spoke" arrangements with other CMHSPs. LifeWays does not provide any direct services. All services are provided through contracted Network Providers. The Substance Abuse Coordinating Agency for Hillsdale and Jackson Counties is Mid-South Substance Abuse Commission. The PIHP and CA are separate entities in Hillsdale and Jackson Counties. In March 2007, Mid South came "to the table" with LifeWays to begin working on a co-occurring integrated diagnostic, screening and assessment point. Currently, Mid South has an Intensive Outpatient program for individuals with co-occurring disorders.

The current Leadership Team for the integrated diagnostic, screening and assessment point is Diane Cranston (Clinical Director -LifeWays), Niki Feller (Access Center Director-LifeWays), Mary Kronquist (COO- Mid South), and Bob Sweet (Director of CDRS- Mid South's contracted agency for its access center). It is expected that Mid South's co-occurring disorder Service Provider will join the Leadership Team in the next quarter. This Leadership Team has the support of Nancy Miller (CEO-LifeWays), Gary Van Norman (CEO- Mid South), and Dr. Mehta (Medical Director-LifeWays). Nancy Miller receives monthly updates from Diane Cranston. Gary Van Norman receives monthly updates from Mary Kronquist. Dr. Mehta receives monthly updates from Diane Cranston and Niki Feller.

The IPLT's expanded role was defined by Nancy Miller, CEO in order to help facilitate a complete system analysis and change, not just EBP implementation. Once the IDDT Providers are identified through an RFP process, the MI-Adult IPLT Subcommittee will be actively involved in the co-occurring system transformation. In February, Mid South recently supported the active participation of an interested staff member on the IPLT. This person will begin attending the IPLT meetings and participation on the MI-Adult subcommittee when she returns from Medical Leave, probably June 2007.

4. **Has a consensus document been developed regarding the overall system change? How widespread is participation within the PIHP/CA system? Submit any documents regarding consensus development, policy direction, and chartering of quality improvement activities that have been developed. Identify any overall system priorities that have been adopted (e.g., welcoming, screening, data collection, etc.).**

A consensus document has not been developed regarding the overall system change.

The Co-occurring Leadership Team mentioned above will be meeting with Network 180 on April 23rd to discuss an integrated access center. From this meeting, we hope to gain an example of a consensus document that we can use as a starting point. LifeWays and Mid South are in agreement in the development of co-occurring substance abuse providers and mental health providers. We also agree that mental health should be the lead on servicing the individuals with serious mental illness found on Quadrant IV and II and substance abuse should be the lead on servicing the individuals with substance abuse disorders found on Quadrant I and III.

Currently, Mid South contracts with Bridgeway in Jackson County to provide co-occurring Intensive Outpatient Substance Abuse Services. Mid South states that their Contracted Providers in Jackson County (3 providers) and Hillsdale County (1 provider) are co-occurring capable.

The identified priorities appear to be an integrated screening, diagnostic and assessment center is the first priority with the identification/development of IDDT teams as a second priority.

No documents have been developed

5. **Describe participation and involvement during the past quarter of elements of the system that are not part of the PIHP/CA service delivery. Include consumer and family stakeholders, primary health care and emergency rooms, criminal justice, homeless services, child welfare, etc.**

There was no participation or involvement of individuals outside of LifeWays or Mid South. When Mid South and LifeWays develop a consensus document, this consensus document will be shared with individuals outside of LifeWays and Mid South.

6. **Has the system done the CO-FIT 100? If so, describe the process, the score, and what action items are being addressed based on that process? If not, what plans are there to use the tool?**

The CO-FIT has not been implemented yet. After the April 23rd meeting with Network 180, LifeWays will be in regular phone contact and monthly face to face contact with Network 180 as they assist LifeWays in completing the CO-FIT 100.

7. **How widely has the system implemented the COMPASS? How many programs have done the COMPASS, and how many plan to? Describe the process for doing the tool, collecting the results, and assisting programs in creating quality improvement action plans to move toward DDC. What is the status of action plan development and progress for participating programs? What plans are there for widening program participation?**

The COMPASS has not been implemented yet. After the April 23rd meeting with Network 180, LifeWays will be in regular phone contact and monthly face to face contact with Network 180 as they assist LifeWays in completing the COMPASS.

8. **How has the system organized quality improvement activities related to monitoring improvement in integrated services? What are the targets and indicators? Has this been linked with existing PIHP or CA quality improvement activities? How is it connected with consensus priorities listed in question #4 above?**

LifeWays' 2 Quality Improvement Specialists have been assigned to the IPLT and the MI Adult Subcommittee. As previously stated the MI Adult Subcommittee will be included as part of the Co-Occurring Leadership Team once the IDDT Providers are chosen. No targets or indicators have been chosen yet. Currently, LifeWays data systems has not accurately recorded the number of individuals in the CA or PIHP system with co-occurring disorders. Processes will be put into place to capture this data in the upcoming quarter. A consensus priority document has not been developed.

9. **What policies and procedures have been articulated or are in process regarding clinical practice development that is universal in the system: welcoming, screening, assessment, treatment planning, stage matching, integrated billing procedures, etc.? Describe the process of development and submit any products.**

No policies and/or procedures have been developed at this time. The meeting with Network 180 on April 23rd is the beginning step of establishing and developing processes and procedures for an integrated screening, diagnostic and assessment process. The Leadership Team has identified the development of a universal screening tool and assessment tool as a priority.

10. **If you have identified a specific team or teams to implement IDDT, who are they and how were they chosen? Where do they fit in to the larger system's movement toward integrated treatment, and how are they supported by their agencies in this process. Describe how the IDDT teams promote practice improvement in the system as a whole.**

The IDDT Providers have not been chosen. It is expected that they will be chosen in the next quarter. The IDDT Providers will be the ACT Providers. The expectation is that IDDT will be integrated into the ACT teams. The CEOs of the ACT Providers have expressed an interest in doing IDDT. The IDDT Providers will be participating in the Train the Trainer Motivational Interviewing Project. These individuals will then assist the Network Providers in becoming co-occurring capable. It is expected that the IDDT Teams will become "experts" and assist the rest of the Providers in developing co-occurring expertise, especially in the area of psychiatric practices.

11. **What activities are in process regarding IDDT team development? Has the Fidelity Scale been used? Did the PIHP utilize or schedule any Michigan Fidelity Assessment and Support Team (MiFAST) fidelity reviews. What other data collection or performance improvement activities are in process related to the IDDT team? What assistance has been provided by national consultants or others to the team, and what is planned or needed for the coming quarter?**

The following activities have taken place regarding IDDT team development:

- Discussion with the CEOs and Clinical Directors who are providing ACT services related to the composition and structure of their ACT teams

- Discussion with the ACT Providers CEOs regarding their interest in providing IDDT services within their ACT teams

- In March, 3 staff members from an ACT Provider attended "Introduction to Diagnosis and Treatment of Co-occurring Disorders" Training.

- Encouraging the attendance for ACT Providers, including medical staff, at co-occurring disorders training such as Dr. Mee Lee's Co-occurring Disorders: Clinical Dilemmas in Diagnosis and Treatment and the Role of the Physician on April 12th and attendance at the Directors Meeting for the Motivational Interviewing Train the Trainer Project

- Encourage the ACT providers to attend the ACT conference sessions on Integrating IDDT into ACT teams, and EBP in the ACT teams

The fidelity scales have not been used yet. The plan is to use the scales in the development of the IDDT RFP. Network 180 will provide guidance on this activity. LifeWays is not ready to schedule a MiFAST fidelity review. Data collection and performance improvement activities are not yet in place for the IDDT team.

No assistance from national consultants was provided this quarter. The plan is for the IDDT providers to be chosen in this upcoming quarter with consultant assistance from Network 180 and for intensive work to occur within the IDDT teams, under the consultant help of Patrick Boyle in the 4th quarter with the Teams ready to implement IDDT practices in October 2007.

12. **What activities have been undertaken regarding clinical practice development, both in the system as a whole and for staff in proposed IDDT teams? Have clinicians been widely informed of the process of change and**

trained in basic principles? Have there been efforts to communicate universal goal of dual competency to all clinicians? Have clinician scopes of practice and core competencies been drafted or are in process? What training efforts have taken place? Has the use of the CODECAT been considered or initiated? If there are clinical training goals (e.g., assessment, treatment planning, motivational interviewing), what policies or procedures are in place to make it likely that clinicians will be organized and expected to begin to use the training in their work?

In terms of clinical practice development, it is expected that the ACT providers send their medical staff to Dr. Mee Lee's upcoming training on Co-occurring Disorders: Clinical Dilemmas in Diagnosis and Treatment and the Role of the Physician Training. It is also expected that LifeWays 2 primary MI-Adult Providers' Directors attend the Motivation Interviewing Train the Trainer Project Information Session in April in order to assist them in identifying 2-3 individuals per agency to participate in this Project. In turn these individuals will train the rest of the Network in Motivational Interviewing.

LifeWays will work with Network 180 and other "exemplary" Co-occurring sites to design the training program for the IDDT teams and other Network Providers. The training program will begin develop in June 2007.

13. **What administrative barriers from the state have emerged as issues during the last quarter? What efforts have been made to overcome those barriers? What would be helpful at this point from the state to address those barriers? What else would be helpful for the state to provide or do to facilitate your progress?**

At this point, no barriers have been identified. The MDCH Specialist has been very helpful, encouraging and supportive.

14. **What internal administrative or clinical barriers have you encountered in the last quarter, and what efforts have you made to overcome them? What technical assistance have you received in the past quarter? Are there areas where you feel that you could use specific technical assistance and/or training in the future?**

In the last quarter, the biggest internal administrative barrier was the resignation of the EBP Coordinator in November 2006. In this quarter, the Clinical Director (IPLT Leader) resigned in January 2007. LifeWays was able to replace the Clinical Director with an internal staff person, but has not yet been able to fill the EBP Coordinator position. However, there is a promising candidate scheduled for an interview on April 23rd. The "New" Clinical Director spent a good part of this quarter educating herself on co-occurring system transformation and the IDDT model versus being able to move the system transformation and IDDT model forward.

In this upcoming quarter, Network 180 will be providing intensive and extensive technical assistant to LifeWays in all areas, starting with co-occurring screening, diagnosis and assessment and choosing IDDT service providers.

15. **If the project is having problems with implementation/continuation, will all of the allocated resources be needed? Should an amendment be initiated?**

It is expected that the allocated resources will be spent primarily in the 4th quarter with the intensive national consultant work with the IDDT Providers.

16. **What are the activities and action plans for the next quarter? Describe how project funding is being used in the coming quarter to support the maximum amount of leverage for practice improvement.**

- Develop a consensus agreement document with Mid-South that includes the vision for an integrated screening, diagnostic, assessment service
- Develop the screening, diagnostic, and assessment tools
- Train the Access Center on these documents
- Complete the GOI, COMPASS and CO-FIT100 Documents
- Write and issue the RFP for the IDDT Teams
- Select IDDT Providers

At this time, in the coming quarter, project "Training funds" will be used to fund the attendance of ACT Providers, including Medical Staff, at Dr. Mee Lee's Co-occurring Disorders: Clinical Dilemmas in Diagnosis and Treatment and the Role of the Physician in April. The attendance of ACT Provider Directors at the Motivational Interviewing Train the Trainer Information Session in May 2007. The majority of the funds will be spent in the 4th quarter to bring in Patrick Boyle to work with our IDDT Providers.

17. **What actions are being taken by LifeWays to sustain this initiative after the block grant period ends?**

The IDDT program will be integrated into LifeWays service array for adults with mental illness. It will be sustained through LifeWays Medicaid and General Fund dollars. It is also expected that LifeWays and Mid-South will develop a funding agreement to share costs for individuals with no insurance.

Agency:
Project title: **MCCMH IDDT Implementation**
Contract number: **20071298-1**
Project number: **20707**
Time period covered: **January 1, 2007 to March 31, 2007**
MDCH Specialists: **Tison Thomas, Patricia Degnan**

1. Include the project title, contract number, project number, time period covered, and MDCH Specialist's name at the top of the report. At the bottom of the report, please include the person's name that completed the report, as well as contact information for that person.

2. Briefly summarize the Systems Transformation efforts and implementation activities of the Improving Practices Leadership Team (IPLT). Describe the activities and actions taken by the IPLT to improve the overall system of care.
   a. The IPLT oversees the implementation of the IDDT COD initiative through regular meetings and sub-committee activity.
   b. The IPLT provides direction regarding other practice transformations, such as incorporation of recovery, coordination with physical health care, self-determination policy and practices, and preparation for using the results of the DCH work group on Autism Spectrum Disorders.
   c. The IPLT assists with the selection and preparation of grant proposals (e.g., the DCH Block Grants) for the implementation of particular clinical practices and programs.

3. Describe the structure within the PIHP and collaborating CMHSPs and CAs that are overseeing the systems change process to support integrated services. Specifically identify leadership team members and state how the leadership team is empowered by the PIHP, CMHSPs, and CAs to oversee the process. What is the level of participation of the CEOs, Medical Directors, and Clinical Directors of each entity? Where does the IPLT fit into the overall structure of the PIHP and CA system, and how is it empowered by system leadership?
   a. Macomb County Community Mental Health (MCCMH) is a single-county, stand-alone PIHP that maintains a panel of providers who deliver specialty mental health services and supports. Some providers are contractual but MCCMH also delivers some services through a staff model. Macomb County Office of Substance Abuse (MCOSA) has been part of MCCMH since the mid-1970's and maintains a panel of contract providers who deliver substance use disorder services. Some of the providers on the MCOSA panel are also part of the MCCMH behavioral health panel.
   b. The IPLT membership includes the Director of Behavioral Health, the Medical Director, and the Deputy Director of MCOSA, as well as quality improvement staff, consumers and family members, and advocates.
   c. The IPLT makes recommendations to the MCCMH Executive Staff, which provides final approval for important actions.

4. Has a consensus document been developed regarding the overall system change? How widespread is participation within the PIHP/CA system? Submit any documents regarding consensus development, policy direction, and chartering of quality improvement activities that have been developed. Identify any overall system priorities that have been adopted (e.g., welcoming, screening, data collection, etc.).
   a. MCCMH has developed and disseminated an Executive Directive describing the core

values and principles of the implementation of the COD.

b. MCCMH continues to revise PIHP policies on an on-going basis to include the COD initiative. PIHP policies are incorporated by reference in all contracts with members of the provider panels.

5. Describe participation and involvement during the past quarter of elements of the system that are not part of PIHP/CA service delivery. Include consumer and family stakeholders, primary health care and emergency rooms, criminal justice, homeless services, child welfare, etc.
   a. Consumer and family stakeholders are part of the IPLT that is overseeing the implementation of the EBP.
   b. Reports are provided to the MCCMH Citizens Advisory Committee as needed.
   c. MCCMH is implementing an outreach team for chronically homeless individuals under a separate DCH block grant. This outreach team will meet many individuals with COD issues and services needs. Discussions with members of the Macomb County Homeless Coalition regarding the outreach team provide regular opportunities to update the coalition members regarding the COD EBP implementation. The outreach team will work in settings that are already being served by the FQHC "look-alike" in Macomb County. This provides additional opportunities for coordination of care with physical health.
   d. MCCMH is an active member of the Macomb MPRI Steering Committee and is contracted with Ufeways to provide services for offenders who have received mental health services in prison as they re-enter the community. The number of individuals re-entering the Macomb community who need both mental health and substance use disorder service is high. The implementation of the COD initiative prepares MCCMH providers to deliver services needed by this population.

6. Has the system done the CO-FIT 100? If so, describe the process, the score, and what action items are being addressed based on that process? If not, what plans are there to use the tool?
   a. The CO-FIT 100 was distributed to the IPLT and formed the basis for early discussions regarding processes of implementation.
   b. The CO-FIT 100 will be completed formerly in the next quarter.

7. How widely has the system implemented the COMPASS? How many programs have done the COMPASS, and how many plan to? Describe the process for doing the tool, collecting the results, and assisting programs in creating quality improvement action plans to move toward DOC. What is the status of action plan development and progress for participating programs? What plans are there for widening program participation?
   a. Programs implementing the IDDT-COD SAMHSA toolkit have completed the COMPASS and CODECAT. The results form the basis for on-going meetings with the providers as they implement COD services.

b. Programs on the MCOSA panel received the COMPASS and CODECAT and are in the process of completing the documents. Results will be collected through the MCOSA staff and analyzed by the Director of Behavioral Health

8. How has the system organized quality improvement activities related to monitoring improvement in integrated services? What are the targets and indicators? Has this been linked with existing PIHP or CA quality improvement activities? How is it connected with consensus priorities listed in question #4 above?
   a. Quality Improvement staff from MCCMH and MCOSA participate regularly in the IPLT. A member of the MCCMH BH QI staff is a member of the MI-FAST group.
   b. The MCCMH QI process will assist in implementing indicators chosen through the IPLT as COD services are implemented.

9. What policies and procedures have been articulated or are in process regarding clinical practice development that is universal in the system: welcoming, screening, assessment, treatment planning, stage matching, integrated billing procedures, etc.? Describe the process of development and submit any products.
   a. MCCMH implemented a new Electronic Medical Record (EMR) on 10/01/06. The EMR contains a screening instrument (the UNCOPE) and materials for assessing substance dependence/substance abuse issues. Its physical health screen also includes questions regarding substance use experiences which are completed by consumers when they complete the health screen. Implementation of the EMR has included implementation of regular screening for substance use issues and follow-up assessment processes.
   b. MCCMH Access Center is the initial central point-of-contact for all new consumers who do not present directly to emergency' rooms of hospitals under contract to MCCMH. The Access Center uses a telephonic screen to determine urgency of need and sets up the initial face-to-face assessments for consumers who appear to be eligible for CMH services on initial information. The MCCMH Access Center has participated with other Boards in the COCE grant managed by Network 180 regarding processes of screening, welcoming, and transfer for services. MCCMH Access Center routinely check with consumers several days after their initial contact to ensure coordination of care and to resolve potential barriers to service that may have arisen after the initial contact. The substance abuse access point, CARE, also participated in the screening pilot. This provided additional feedback to the process.

10. If you have identified a specific team or teams to implement IDDT, who are they and how were they chosen? Where do they fit in to the larger system's movement toward integrated treatment, and how are they supported by their agencies in this process. Describe how the IDDT teams promote practice improvement in the system as a whole.
    a. Four teams have been identified to implement the IDDT-EBP COD SAMHSA "toolkit" model. One team is part of an integrated inpatient-outpatient system of care under

contract to the Board. A second team has been developed by a large contract provider, who also provides clubhouse services, residential services, outpatient services, and is simultaneously working on an outreach team for the chronically homeless in Macomb County. The third and fourth teams implementing the IDDT-COD are directly operated by the MCCMH Board as part of the continuum of care. One of the teams is an ACT team and the other is part of the community-based intensive case management unit for adults with SMI. These teams were identified to implement the IDDT in order to provide a variety of learning experiences to MCCMH regarding how COD services can be implemented throughout all relevant providers on its panels.

b. Each of the teams leading the implementation of COD services are embedded in a larger provider continuum. Each implementation will set the stage for wider implementation of COD services by inpatient, residential, and outpatient service providers.

11. What activities are in process regarding IDDT team development? Has the Fidelity Scale been used? Did the PIHP utilize or schedule any Michigan Fidelity Assessment and Support Team (MiFAST) fidelity reviews. What other data collection or performance improvement activities are in process related to the IDDT team? What assistance has been provided by national consultants or others to the team, and what is planned or needed for the coming quarter?
    a. The first and second IDDT teams are beginning operation. The Fidelity Scales have been used as the bases for planning sessions leading to implementation. Therefore, the teams have been constructed with the Fidelity Scales in mind, although they are not likely to be fully in place until each teams has reached "critical mass" during the implementation process.
    b. The third and fourth teams are undergoing additional training regarding substance abuse issues and interventions prior to initiation since the staff who are on these teams are existing staff rather than staff hired specifically for their pre-existing expertise and experience with substance abuse and COD issues. This training will continue through the next quarter. It is expected that the third team will work first with consumers already enrolled in the ACT teams, since there are a number of persons with COD active with those teams. The fourth team will begin operation as they are able to reduce their caseloads to the proper staff-consumer ratio.
    c. Dr Cline visited MCCMH in 2006 and met with the leadership of the teams.
    d. Team members, along with staff from other provider agencies on the MCCMH behavioral health panel and on the MCOSA substance abuse panel, have received training from Dr. Mee-Lee, Michael Clark, and local presenters.
    e. Leaders of the team are expected to participate in mutual collaboration meetings in the next quarter.

12. What activities have been undertaken regarding clinical practice development, both in the

system as a whole and for staff in proposed IDDT teams? Have clinicians been widely informed of the process of change and trained in basic principles? Have there been efforts to communicate universal goal of dual competency to all clinicians? Have clinician scopes of practice and core competencies been drafted or are in process? What training efforts have taken place? Has the use of the CODECAT been considered or initiated? If there are clinical training goals (e.g., assessment, treatment planning, motivational interviewing), what policies or procedures are in place to make it likely that clinicians will be organized and expected to begin to use the training in their work?

a. MCCMH has conducted panel-wide trainings regarding the IDDT COD implementation. Providers of services to Adults with SMI on the MCCMH Behavioral Health panel and providers of substance use disorders services on the MCOSA provider panel have been involved. Providers have been instructed regarding three levels of participation (Dual Disorder Capable, Dual Disorder Enhanced, and Dual Disorder "toolkit" implementation) and informed that they will be expected to self-identify their future participation within those opportunities.
b. MCCMH and MCOSA have sponsored trainings with Dr. Mee-Lee, including some specifically addressed to psychiatrists, and with Michael Clark to prepare all providers for their future roles. MCCMH and MCOSA is delivering a series of training regarding substance use disorder services to MCCMH staff. Units have completed the CODECAT.

13. What administrative barriers from the state have emerged as issues during the last quarter? What efforts have been made to overcome those barriers? What would be helpful at this point from the state to address those barriers? What else would be helpful for the state to provide or do to facilitate your progress?
    a. The recent Social Work licensure Law has redefined the scope of practice for Bachelor's Level social workers. This presents difficulty in implementing COD services if BSW staff cannot bill for a wider range of services. Modifications in the Social Worker licensing process or adaptations in the billing parameters in the Medicaid Manual are needed.
    b. Changes suggested by the Office of Drug Control Policy in credentialing of substance use disorder service workers and programs will increase disparities between MCOSA and MCCMH contract expectations and allowances. Improved coordination of projects between DCH and the ODCP are recommended, especially in regard to the implementation of the AAR (AMS) and the motivational interviewing train-the-trainer project.

14. What internal administrative or clinical barriers have you encountered in the last quarter, and what efforts have you made to overcome them? What technical assistance have you received in the past quarter? Are there areas where you feel that you could use specific technical assistance and/or training in the future?
    a. MCCMH has participated in the COCE-sponsored, Network 180 managed

consultation and technical assistance regarding initial screening process and welcoming at point of initial contacts with MCCMH.

b. Contract negotiations with contract providers implementing COD services took longer than anticipated due to concerns about costs, utilization, and accomplishment of fidelity. Persistence has paid off.
c. Preparation for COD services by clinical teams employed directly by MCCMH had to address existing skills sets of the staff. A training series was devised and is being implemented. It will prepare the staff implementing the COD "toolkit" model and will also prepare staff who will implement Dual Disorder Enhanced services in outpatient settings serving Adults with Serious Mental Illness.
d. Preparation for COD services by an existing ACT service team builds on the fidelity of the implementation of the ACT EBP. The IPL T has recommended that a review of ACT fidelity be conducted. Negotiations with staff from the ACT Center of Indiana are underway.

15. If the project is having problems with implementation/continuation, will all of the allocated resources be needed? Should an amendment be initiated?
    a. The implementation simply takes more time that expected. Resources must be used as the teams and systems reach the point of readiness for particular steps. Extension of time to use allocated resources may be needed, but it is premature to initiate a contract amendment at this time.

16. What are the activities and action plans for the next quarter? Describe how project funding is being used in the coming quarter to support the maximum amount of leverage for practice improvement.
    a. The initial teams will expand their services.
    b. The other teams will complete their additional training series.
    c. ACT fidelity assessment will take place.

17. What actions are being taken by the PIHP to sustain this initiative after the block grant period ends?
    a. The teams implementing COD will be using capitation resources for service provision. This process does not depend on grant status and will continue after the end of the grant period.
    b. The effect of COD services from the teams will continue to spread to other service programs within the same providers.

ATTACHMENT C- CO OCCURRING DISORDERS
NARRATIVE REPORTING REQUIREMENTS

Report Period:

January 1, 2007 to March 30, 2007
PHIP: Lakeshore Behavioral Health Alliance
Program Title: Integrated dual disorders Treatment
Executive Director: James Elwell
Address: 376 Apple Ave., Muskegon, Michigan 49442
Contact person: Glenn Eaton
Phone: 231-724-1106, Fax.: 231-724-1300 e-mail:
smitht@mchs.co.muskegon.mi.us
PCA # 20708 Contract # 20061244 Federal ID # 38-6006063

2. Briefly summarized the Systems Transformation efforts and implementation activities of the Improving Practices Leadership Team (IPLT). Describe the activities and actions taken by the IPLT to improve the overall system of care.

During the second quarter of FY06/07, the Lakeshore Behavioral Health Alliance (LBHA) Improving Practices Leadership Team (IPLT) continued to meet on a monthly basis to provide oversight of the Family Psychoeducation, Integrated Dual Disorders Treatment, Parent Management Training, and Recovery/WRAP Implementation teams.

The following activities and actions were undertaken by the IPLT to improve the overall system of care within the Affiliation:

- Motivational Interviewing Training, presented by Michael Clark, got underway during the quarter. By June 2007, it is anticipated that well over 100 Affiliation staff will have completed this four-day training.

- Planning took place to implement a WRAP group for Muskegon CMH staff in April in order to give them firsthand experience with this effective Recovery tool.

- Information regarding a comprehensive recovery training curriculum for staff was obtained from META Services, Inc. It will be evaluated for possible use with LBHA staff.

- The ROSI was reviewed and piloted on a limited scale.

- IPLT members increased their knowledge of the Supported Employment Evidence-Based Practice Model and strongly support LBHA applying for FY07/08 Mental Health Block Grant funds to assist in this implementation.

- Monthly "Tools for Transformation" articles from the journal *Behavioral Healthcare* have been reviewed and discussed in an effort to establish an

extensive tool chest for transforming Muskegon and Ottawa CMHs into truly recovery-based organizations.

- Four IPLT members attended the two CMH Board Association preconference institutes on February 26, 2007, that addressed implementation of evidence-based practices and reported back to the IPLT. As a result, steps have been taken to provide staff members who have gone through motivational interviewing training with regularly scheduled practice opportunities to improve their skill level.

- IPLT has strongly supported the hiring of additional peer support specialists by the affiliates and will continue to monitor progress.

3. Describe the structure within the PIHP and collaborating CMHSPs and CAs that are overseeing the systems change process to support integrated services. Specifically identify leadership team members and state how the leadership team is empowered by the PIHP, CMHSPs, and CAs to oversee the process. What is the level of participation of the CEOs, Medical Directors, and Clinical Directors of each entity? Where does the IPLT fit into the overall structure of the PIHP and CA system, and how is it empowered by system leadership? Has a consensus document been developed regarding the overall system change? How widespread is participation within the PIHP/CA system? Submit any documents regarding consensus development, policy direction, and chartering of quality improvement activities that have been developed. Identify any overall system priorities that have been adopted (e.g., welcoming, screening, data collection, etc.).
There have been no further changes to the consensus document. Our last version (#5) is attached. Both counties continue to work with stakeholders and substance abuse providers in their area.

In Ottawa Co. upper management (Gerry Cyranowski, Sue Buist) provide administrative support for the project. Developments documents and service ideas are reviewed quarterly at the Leadership Group meeting. IDDT steering committee staff (Pat O'Rourke, Jane Longstreet, and Vicki Berhuis) is instrumental in the design of the IDDT program. An assessment tool was developed by a joint Muskegon-Ottawa team and incorporates staging and a comprehensive section on substance use history. Both counties have conducted surveys of current dual consumers and are developing eligibility requirements for an IDDT team. Ottawa has revised its inactive consumer policy to reflect a welcoming orientation.

4. Describe participation and involvement during the past quarter of elements of the system that are not part of PIHP/CA service delivery. Include consumer and family stake holders, primary health care and emergency rooms, criminal justice, and homeless services, child welfare, etc. In Muskegon Co., CMH staff is meeting regularly with two work groups:
    a. The Inner-agency Jail/corrections work group has been meeting for over

year to develop improved services for the mentally ill and dually diagnosed consumers. Current priority of an additional work group includes the design of a screening—assessment program for citizens in contact with police and exhibiting symptoms of illness. Muskegon Co officials would like to build a new jail and have asked CMH to assist with the design of improved services.

b. Muskegon CMH staff continues to meet monthly with a community Substance Abuse Treatment Collaborative. Several items are priorities for discussion: the need for detox services and the need for half-way house programming. The committee is a forum to exchange programming information and discuss methods to improve service and communication. This group will be targeted for further work with the CCISC document during the next quarter.

5. Has a consensus document been developed regarding the overall system change?

   The last version of the consensus document (#5) continues to be the format we are utilizing. The next step is to present this document to our Affiliation managers for signature and then promote its acceptance to area agencies. We continue to work on relationships with stakeholders and partner agencies.

6. Describe participation and involvement during the past quarter of elements of the system that are not part of PHIP/CA service delivery.

   Both counties are involved in jail diversion service development. Both counties worked with law enforcement to implement an agreed upon Coordination of Care Agreement for mentally ill and dually diagnosed individuals. This document describes emergency care for citizens in crisis and has been endorsed by area police departments and CMH.

7. Has the system done the CO-FIT 100? If so, describe the process, the score, and what action items are being addressed based on that process? If not, what plans are there to use the tool?

   The system has not done a CoFit. However, it is a goal of the steering committee to conduct a review of the CCISC and conduct a CoFit evaluation and derive further action steps from the results. In Ottawa Co. representative of Pine Rest, CMHOC, Pathways, Catholic Social Services, Zeeland Hospital, Holland Hospital, No. Ottawa Hospital, OAR Drug Court, Shoreline Consultation Services, Intercare, Holland Rescue Mission, and consumers advocacy groups continue to meet at our monthly COD consensus meeting. Next action steps for this group include completing the Co-Fit in May, and charting how all agencies fit into the four quadrant model. Additionally, the IDDT steering committee has been instrumental in advocating and assisting consumers in the implementation of Dual Recovery Anonymous groups.

ATTACHMENT C- CO OCCURRING DISORDERS
NARRATIVE REPORTING REQUIREMENTS

8. How widely has the system implemented the COMPASS? How many programs have done the COMPASS, and how many plan to? Describe the process for doing the tool, collecting the results, and assisting programs in creating quality improvement action plans to move toward DDC. What is the status of action plan development and progress for participating program? What plans are there for widening program participation?

   The COMPASS was conducted by the two county clinical staff during the past year, and action plans have been developed based on outcomes.

   a. The action plan for the final two quarters is attached.

9. How has the system organized quality improvement activities related to monitoring improvement in integrated services? What are the targets and indicators? Has this been linked with existing PIHP or CA quality improvement activities? How is it connected with consensus priorities listed in question # 4 above?

   Both counties continue to work on improving staff clinical competence. In Muskegon Co. the following activities have occurred this quarter:

   a. Two groups of staff attended four day Motivational Interviewing training by Michael Clark, MSW. Seventy staff has now received training.
   b. 50 case managers attended at two hour substance abuse training with Cathy Hart, MA. Ottawa CMH will be beginning Motivational Interviewing training April 26 and an additional 40 staff will be trained. Our next step is to begin to develop integrated staging of dual consumers, with treatment planning developed to match. The Ottawa dual diagnosis psychoeducatinal groups have been selected to become staged by June 1st. The SOCRATES is being employed to assess stage of change for each member of the current groups as well as for any new referrals to these groups. Staff representing each service program within CMHOC has been instructed on how to assure that substance use diagnoses are entered into the data system.

9. What policies and procedures have been articulated or are in process regarding clinical practice development that is universal in the system: welcoming, screening, assessment, treatment planning, stage matching, integrated billing procedures, etc.? Describe the process of development and submit any products. The Steering Committee targeted administrative policies and procedures to be completed during this next quarter. In both counties program descriptions are being revised to reflect welcoming of individuals with co-occurring disorders. In Ottawa Co. the client inactive consumer policy has been revised to reflect welcoming of individual who require episodic care. The

CMHOC policy on alcohol and drug abuse is scheduled to be revised by the CMHOC IDDT steering committee.

10. If you have identified a specific team or teams to implement IDDT, who are they and how were they chosen? Where do they fit in to the larger system's movement toward integrated treatment, and how are they supported by their agencies in this process. Describe how the IDDT teams promote practice improvement in the system as a whole. The steering committee has recommended the development of IDDT teams in each county. A presentation will be made to the PIHP Affiliate Council May 3, 2007. Currently in Ottawa Co. steering team staff is designing team models for consideration. Given that this will involve rearranging existing service teams, decisions have not yet been finalized as to the specific individuals. CMHOC is proposing a 5 person team made up of a team leader, a substance abuse specialist, 2 case managers, part-time nursing and psychiatric resources and a peer specialist. The goal is to offer discrete IDDT programming in the larger CMH system that utilizes CCISC principles throughout.

11. What activities are in process regarding IDDT team development? Has the Fidelity Scale been used? Did the PIHP utilize or schedule any Michigan Fidelity Assessment and Support Team (MiFAST) fidelity reviews. What other data collection or performance improvement activities are in process related to the IDDT team? What assistance has been provided by national consultants or others to the team, and what is planned or needed for the coming quarter?

    Both counties continue to look at the logistics of organizing an IDDT team. Ottawa Co. conducted a pre-IDDT review with Patrick Boyle and Steve Wieland in February and received input on program design. Consumers have been identified, based on the severity and complexity of their treatment needs, for inclusion in IDDT services once these services are available.

11. What activities have been undertaken regarding clinical practices development, both in the system as a whole and for staff in proposed IDDT teams? Have clinicians been widely informed of the process of change and trained in basic principles? Have there been efforts to communicate universal goal of dual competency to all clinicians? Have clinician scopes of practice and core competencies been drafted or are in process? What training efforts have taken place? Has the use of the CODECAT been considered or initiated? If there are clinical training goals (e.g., assessment, treatment planning, motivational interviewing), what policies or procedures are in place to make it likely that clinicians will be organized and expected to begin to use the training in their work?

    The work plan for the remaining six months includes the implementation of the CODECAT to review staff competency. The results will be a part of the design of

further training and action steps in the next stage of development. Most clinical staff attended an introductory workshop with Dr. Ken Minkoff a year ago. Now with motivational interviewing training and basic substance abuse training, we are working towards staff competence in assessing stage of change and developing treatment approaches. Ottawa staff conducts a quarterly meeting with all clinicians to advance the principles and specific application of a transformed mental health delivery system. Once we have established who will be assigned to the IDDT team we will focus on specific training needs of those individuals including having them observe other IDDT dual diagnosis service delivery programs. Efforts are underway within Ottawa CMH to build competency requirements for persons with CAC licensure.

13. What administrative barriers from the state have emerged as issues during the last quarter? What efforts have been made to overcome those barriers? What would be helpful at this point from the state to address those barriers? What else would be helpful for the state to provide or do to facilitate your progress?

Continued support and training from the state will be very helpful. We look forward to the Patrick Boyle supervisory training. Training to further staff competency in treating co-occurring consumers would be welcomed. Hopefully DCH review staff is aware that CMH staff will be designing treatment planning that is more focused on the stage of change and the priorities of the consumer. The Lakeshore steering committee staff support the state's efforts to meld MI and SA services into one behavioral health management structure. We would like further clarification on the requirements to use new codes and the new integrated licensing structure.

14. What internal administrative or clinical barriers have you encountered in the last quarter, and what efforts have you made to overcome them? What technical assistance have you received in the past quarter? Are there areas where you feel that you could use specific technical assistance and/or training in the future?
Several issues remain constant: If the project is having problems with implementation/continuation, will all of the allocated resources be needed? Should an amendment be initiated?

Both counties support the development of enhanced services, but struggle with the capacity demands which already stress staff time and finances. These new changes create multiple competing demands for both clinical and administrative energies.

15. If the project is having problems with implementation/continuation, will all of the allocated resources be needed? Should an amendment be filed?
It is expected that all of the resources will be utilized.

ATTACHMENT C- CO OCCURRING DISORDERS
NARRATIVE REPORTING REQUIREMENTS

16. What are the activities and action plans for the next quarter? Describe how project funding is being used in the coming quarter to support the maximum amount of leverage for practice improvement?

Please see last two quarters work plan. Continued training on Motivational Interviewing and stage of change treatment design will be the funding priority.

17. What actions are being taken by the PIHP to sustain this initiative after the block grant period ends?

As an IDDT team and staff become more competent, it will be expected that treatment services will continue as an integrated part of services.

IDDT Quarterly Report

2. Briefly summarize the Systems Transformation efforts and implementation activities of the Improving Practices Leadership Team (IPLT). Describe the activities and actions taken by the IPLT to improve the overall system of care.

Network180 has continued consultation with Dr. Ken Minkoff and Dr. Chris Cline. The structures created to support the development and implementation of CCISC remain in active and involved. These include the CCISC Leadership Team, the CCISC Team/Trainers, and the CCISC Curriculum Group.

The Improving Practices Leadership Team (IPLT) continues to meet on a monthly basis. The IPLT has been following the Action Plan that was developed in 2006 and has focused on the following activities:

- Review of evidence based practice (EBP) currently in use in our system. During the past quarter, the following EBPs were reviewed:
  - Multi Systemic Therapy
  - Parent Management Training-Oregon Model
  - Supported Employment

- The Improving Practices Leadership Team has not confined its review to established EBPs, but is also reviewing emerging practices that are not researched based.

- The IPLT Data Team, which is made up of Network180 and provider staff, are in the process of reviewing the data that is available from the Network180 system and provider system regarding evidence based practices.

- Network180, in cooperation with Grand Valley State University, developed the Evidence Based Practice Survey Report. The report is based on a questionnaire that was sent to all of the Network180 service providers.

- The Improving Practices Leadership Team received regular reports from the Recovery Council, from the Network180 Research Committee, and from the MiFast Representative who sits on the Improving Practices Leadership Team.

3. Describe the structure within the PIHP and collaborating CMHSPs and CAs that are overseeing the systems change process to support integrated services. Specifically identify leadership team members and state how the leadership team is empowered by the PIHP, CMHSPs, and CAs to oversee the process. What is the level of participation of the CEOs, Medical Directors, and Clinical Directors of each entity? Where does the IPLT fit into the overall structure of the PIHP and CA system, and how is it empowered by system leadership?

Network180 is the PIHP, the CMH, and the CA. The CCISC Leadership Team is made up of the Executive Directors of a number of mental health and substance abuse providers for adults and children's services. The role of this group is to guide and lead the CCISC implementation in the Network180 provider system.

Mike Reagan	President, Proaction
Jack Greenfield	President, Arbor Circle Corporation
Greg Dziadosz	President, Touchstone innovare
Sharon Loughridge	President, DA Blodgett
Al Jansen	Pine Rest Christian Mental Health Services
Tom Moore	Clinical Supervisor, Life Guidance Services
George Tyndall	Clinical Supervisor, Bethany Christian Services

Network180 has encouraged the involvement of Medical Directors and psychiatric staff in the CCISC initiative. The Medical Directors and psychiatrists have met with Dr. Minkoff and Dr. Cline on each of their visits to Network180.

The Improving Practices Leadership Team has Network180 representation from the MISUD Adult Team and the Children's Team. There are also representatives from the mental health and substance use disorder treatment systems, adult and children.

4. Has a consensus document been developed regarding the overall system change? How widespread is participation within the PIHP/CA system? Submit any documents regarding consensus development, policy direction, and chartering of quality improvement activities that have been developed. Identify any overall system priorities that have been adopted (e.g., welcoming, screening, data collection, etc.).

Network180 has developed the CCISC consensus document 2007. This document has been signed by all of our mental health and substance abuse providers of adult and children's services.

In 2006, the system priorities for Network180 included welcoming, screening, and data collection. A process improvement team was convened to address each of these areas. A collaboration between the Screening and Data PITS lead to the development of the COD Data Project. This project is designed to determine the prevalence of diagnosed COD, as well as Pre COD. Pre COD has been defined as the presence of indicators that fall short of meeting the DSM IV criteria for a mental health and a substance use disorder. It was determined that this information was valuable to service planning, client placement/referral and clinical interventions. See # 8.

5. Describe participation and involvement during the past quarter of elements of the system that are not part of PIHP/CA service delivery. Include consumer and family stakeholders, primary health care and emergency rooms, criminal justice, homeless services, child welfare, etc.

Network180 is committed to collaboration with community providers and partners. Network180 staff members participate in the following collaboratives:

- Vision to End Homelessness-
- StreetReach Community Advisory Team-housing, physical health, police department, homeless services-monthly meeting
- StreetReach Stakeholder Group- housing, shelter system, police department, community health centers, DHS, employment services-February 2007
- Kent County Family and Children's Coordinating Council-DHS, service providers
- Prostitution Roundtable-61st District Court, Social Work and Police Partnership (SWAPP), service providers, housing

6. Has the system done the CO-FIT 100? If so, describe the process, the score, and what action items are being addressed based on that process? If not, what plans are there to use the tool?

Network180 completed the CO-FIT in September 2006. Network180 administrative staff, Access Center staff, and Contract Managers from the MISUD Team and the Children's Team participated. In discussion with the CCISC Leadership Team, it was determined that before we developed any process improvement teams from the CO-FIT, that we should develop a long range plan for CCISC. The CCISC Leadership Team held two half-day planning sessions and developed three goals with timelines.

7. How widely has the system implemented the COMPASS? How many programs have done the COMPASS, and how many plan to? Describe the process for doing the tool, collecting the results, and assisting programs in creating quality improvement action plans to move toward DDC. What is the status of action plan development and progress for participating programs? What plans are there for widening program participation?

The CCISC Consensus Document 2007 provides for an incentive for completion of the COMPASS on an annual basis, and development of an Action Plan based on the COMPASS. The providers conduct the COMPASS independently; Network180 staff members are involved by invitation only. Network180 staff members are available for consultation regarding the administration of the COMPASS and for technical assistance in action plan development/implementation. Network180 does not collect the results of the COMPASS. Network180 convenes a meeting approximately twice a year of all of the Network180 providers. Each provider offers a general description of their experience with the COMPASS and describes progress on the Action Plan. Action Plans are copied for distribution to all of the meeting participants.

8. How has the system organized quality improvement activities related to monitoring improvement in integrated services? What are the targets and indictors? Has this been linked with existing PIHP or CA quality improvement activities? How is it connected with consensus priorities listed in question #4 above?

In 2006, Network180 created a Process Improvement Team that included Network180 and provider staff that focused on screening for COD. A similar team was created to look at data collection. After a period of time, it was determined that these teams were interconnected and they began to work in collaboration with one another. The result is the Network180 COD Data Collection Project. A mechanism was developed for collecting data on co-occurring disorders that are identified through the screening process. The mechanism involved a change to the network180 authorization system. A drop down box was added to allow the following designations: (0) Neither Disorder (1) Single Disorder (2) Pre COD (3) COD. The data collection process was piloted at our Access Center, and at two providers sites. The mechanism was added to the network180 authorization screen for voluntary system wide use on October 1, 2006, and was mandated January 1, 2007. This will enable Network180 and system providers to determine the prevalence of co-occurring disorders.

Network180 is currently conducting an analysis of the data collected thus far. The data has been reported to the individual providers so they may conduct their own analysis. At this point, the data seems consistent with national data.

Additionally, Network180 offered the Data Collection Project to other PIHPs as part of the COCE consultation.

9. What policies and procedures have been articulated or are in process regarding clinical practice development that is universal in the system: welcoming, screening, assessment, treatment planning, stage matching, integrated billing procedures, etc.? Describe the process of development and submit any products.

As stated previously, participation in the Network180 Date Collection Project became a system requirement on January 1, 2007. There has been discussion regarding practice guidelines for welcoming, assessment, treatment plans, and stage match interventions. A team of provider and Network180 staff has been identified to develop clinical practice guidelines. This work was scheduled to begin in the 2nd quarter. A subgroup of the CCISC Team/Trainers has been formed to address clinical competencies related to COD. The subgroup met on two occasions in the 2nd quarter.

10. If you have identified a specific team or teams to implement IDDT, who are they and how were they chosen? Where do they fit in to the larger system's movement toward integrated treatment, and how are they supported by their agencies in this process. Describe how IDDT teams promote practice improvement in the system as a whole.

Network180 has identified three case management agencies to implement IDDT: Touchstone innovare, Hope Network, and Gerontology Network. Each of these agencies was an active participant in the CCISC initiative prior to their involvement in IDDT. Each of the agencies has signed the Consensus Document 2007. The implementation of IDDT has allowed them to develop a more focused effort that is part of the broader plan to develop co-occurring case ability in their agency.

11. What activities are in process regarding IDDT team development? Has the Fidelity Scale been used? Did the PIHP utilize or schedule any Michigan Fidelity Assessment and Support Team (MiFAST) fidelity reviews. What other data collection or performance improvement activities are in process related to the IDDT team? What assistance has been provided by national consultants or others to the team, and what is planned or needed for the coming quarter?

Touchstone innovare, Hope Behavioral, and Gerontology Network completed the Fidelity Measure in 2006. Touchstone had a face-to-face consultation with Patrick Boyle in March 2006, and a MiFAST Fidelity Measure in July 2006. Hope Behavioral and Gerontology Network also had consultation with Patrick Boyle. The consultation to Touchstone was funded by DCH, Network180 funded the consultation to the two other agencies. Additional consultation with Patrick Boyle is planned for this year. In collaboration with the IDDT providers, Network180 created the IDDT Evidence Based Practice Quarterly Report.

Network180 has contacted Wayne State to schedule consultation with Boyle and MiFAST fidelity reviews for 2007.

12. What activities have been undertaken regarding clinical practice development, both in the system as a whole and for staff in proposed IDDT teams? Have clinicians been

widely informed of the process of change and trained in basic principles? Have there been efforts to communicate universal goal of dual competency to all clinicians? Have clinician scopes of practice and core competencies been drafted or are in process? What training efforts have taken place? Has the use of the CODECAT been considered or initiated? If there are clinical training goals (e.g., assessment, treatment planning, motivational interviews), what policies or procedures are in place to make it likely that clinicians will be organized and expected to being to use the training in their work?

The CCISC curriculum team developed the following training modules for use throughout the Network180 system:

- Welcoming
- Stages of Change
- Introduction to Substance Use Disorders
- Introduction to Mental health Disorders
- Relapse Prevention
- Motivational Interviewing

In 2005, Kathy Sciacca provided a 3 day training for 40 system clinicians and supervisors in the use of Motivational Interviewing. Additionally, 19 of the 40 also received an additional 2 days of training to enable them to train their program staff in Motivational Interviewing. The group developed the 5 two-hour training modules in motivational interviewing highlighted above.

The CCISC Consensus Document 2006 and 2007 offers an incentive for the development and implementation of a training and supervision plan regarding co-occurring disorders. Some providers have used the CODECAT as part of their plan, but it has not been required.

Additionally, all system clinicians who are responsible for requesting authorization from the Network180 system have been trained in the COD Data Collection Project.

Ken Minkoff M.D. and Chris Kline M.D. presented training on the Integrated Longitudinal Strength Based Assessment (ILSA) in December of 2006. This training was open to the CCISC team trainers, as well as additional supervisory/leadership staff.

Network180 received FBG funding to provide training in SUD intervention skills to mental health case mangers. The first of these trainings is scheduled for May 9 and 10 2007.

13. What administrative barriers from the state have emerged as issues during the last quarter? What efforts have been made to overcome those barriers? What would be helpful at this point from the state to address those barriers? What else would be helpful for the state to provide or do to facilitate your progress?

We continue to have difficulty with the apparent contradictions in the scope of practice for bachelor's level staff as defined by the following sources:

- Social Work Licensing Regulations
- Public Health Code

In statewide discussions, it appears that the CMH/PIHPs have made their own attempts to reconcile the contradictions, but in a manner that is not planned or coordinated as a

group. It would be helpful if the state could offer some interpretation or direction that we could all follow, so that we aren't all struggling with the same issue, independent of one another.

Network180 has had internal discussions, and plans to seek interpretation from the Licensing Board.

14. What internal administrative or clinical barriers have you encountered in the last quarter, and what efforts have you made to overcome them? What technical assistance have you received in the past quarter? Are there areas where you feel that you could use specific technical assistance and/or training in the future?

The IDDT providers have identified a need for more expertise in the area of Substance Use Disorders. Network180 received a Federal Block Grant to provide training in SUD treatment, interventions, and supervision to all of the case managers and supervisors in the Network180 system; this would include each of the IDDT providers. The first training is scheduled for May 2007.

15. If the project is having problems with implementation/continuation, will all of the allocated resources be needed? Should an amendment be initiated?

There is no need for an amendment.

16. What are the activities and action plans for the next quarter? Describe how project funding is being used in the coming quarter to support the maximum amount of leverage for practice improvement.

The Network180 EBP IDDT report asks for details of IDDT activity from each of the funded providers. There is an expectation that an action plan will be developed from the IDDT fidelity measures and that action plan will provide service improvement. Network180 will meet with all of the IDDT providers for review of the reports and action plans.

17. What actions are being taken by the PIHP to sustain this initiative after the block grant period?

The continuation of the CCISC initiative will help to sustain the gains made through the funding of IDDT programs.

1. **Project Title:** Co-occurring Disorders: Integrated Dual Disorders Treatment
Contract Number: 20071294
Project Number: 20712
Time Period: January 1, 2007 – March 31, 2007
MDCH Specialist: Tison Thomas

2. **Briefly summarize the Systems Transformation efforts and implementation activities of the Improving Practices Leadership Team (IPLT). Describe the activities and actions taken by the IPLT to improve the overall system of care.**

The Improving practices Leadership team continues to meet on at least a quarterly basis. The last meeting was held in Cadillac on 3/5/07. The IPLT continues to monitor and facilitate implementation of future evidence based promising, emerging practices as part of the systems transformation efforts. The Northwest CMH Affiliation continues to move past the initial planning and is in the implementation phase of IDDT-COD EBP (Evidence Based Practice for adult SPMI and SMI with co-occurring disorder COD). NLCMH currently has one IDDT team on line in the Traverse City office. The WMCMH office plans to begin IDDT services this spring and the NLCMH Southeast offices will begin this spring or early summer. The Northwest CMH Affiliation continues to work with Dr.'s Minkoff and Cline on the overall systems transformation efforts, and has recently completed its second COFIT. This has been reviewed by Ken Minkoff, who provided consultation specific to improving Welcoming and Accessibility. The recommendations will be incorporated into the current work plan and policies and procedures.

The Improving Practices Leadership Team (IPLT) continues to serve as a conduit to provide information to the community relative to systems transformation. Our team continues to monitor and facilitate implementation of future evidence based, promising, and emerging practices as part of the bigger picture of systems transformation.

3. **Describe the structure within the PIHP and collaborating CMHSPs and CAs that are overseeing the systems change process to support integrated services. Specifically identify leadership team members and state how the leadership team is empowered by the PIHP, CMHSPs, and CAs to oversee the process. What is the level of participation of the CEOs, Medical Directors, and Clinical Directors of each entity? Where does the IPLT fit into the overall structure of the PIHP and CA system, and how is it empowered by system leadership?**

As stated in the first quarterly review, The IPLT has continued to meet quarterly although with the modification of our Affiliation PIHP structure now directly reports to the Joint Leadership Team (JLT) and coordinates with other standing PIHP committees. The JLT is supported in its work by the Joint Executive Team (JET) whose members include Greg Paffhouse, NLCMH CEO, Bill Slavin, Chief Managed Care Officer, and Rich VandenHeuvel, West Michigan Community Mental Health Systems CEO) which meets twice monthly. The JLT meets monthly and its members include staff from both Affiliates and who serve to provide direction, leadership and support to PIHP operations. Current JLT members are: Dave Branding, Bruce Bridges, Julie Burke, Lisa Hotovy, Terri Kelty, Chuck Kopinski, Greg Paffhouse (CEO), Bill Slavin (Chief Managed Care Officer), Emily Smiddy, Rich VandenHeuvel and Becky Vincent. In addition David Riddle, DO (medical director) serves as an ad hoc JLT member and sits on assigned PIHP committees.

The JLT roles and responsibilities include the following:

- Will address the functions of the systems team to ensure they are being met
- Will reinforce the affiliation structure and PIHP focus
- Ensure resources and support are necessary to support PIHP operations (including evidenced based practice implementation)
- Ensure compliance with BBA Standards
- Ensure the affiliation is prepared for site reviews
- Act on recommendations, approve policies and other items, identify priorities and assign responsibilities

Shown below is the current IPLT membership:

Improving Practices Leader	Bill Slavin
Specialist in MI Services	Josh Snyder
Specialist in SED Services	Richard Osburn
Specialist in DD Services	Darryl Goodman
Specialist in SA Services	Dennis Priess
Finance	Lauri Fischer
Data	Chuck Kopinski
Evaluation	Travis Merz
Consumer Employed by PIHP	Nanette Marvin
Family Member of a Child	Jane Sank
Lead for COD	Joe Garrity
Lead for PTMO	Mary Hubbard
Leader for peer-operated services	Ernie Reynolds
Peer Support Specialist	Mary Beth Evans
Family Psychoeducation	Dave Byington
Psychiatrist	Dr. Curt Cummins
Director of QI	David Branding
Clinical Director (WMCMHS)	Emily Smiddy

The IPLT oversees the COD Leadership team. This team consists of Bill Slavin Improving Practices Leader, Joe Garrity Lead for COD, Josh Snyder, Specialist in MI Services Josh Snyder from WMCMH, Sue Winters represents the local CA Northern Michigan Substance Abuse Services. Joanie Blamer Emergency Services/Adult Supports Supervisor, from NLCMH SE has been added to the team. THE COD Leadership Team has compiled and submitted the Block Grant requests as well as quarterly reports. The team has completed a second COFIT and is in the process of developing action plans to improve the Welcoming and Accessibility Domains listed in the COFIT. Separate work committees are focusing on these two domains. Josh Snyder is working with the Access/ Welcoming Work group and Joanie Blamer is working with the Accessibility Workgroups; these groups will report to the COD leadership team which will in turn report to the IPLT. Linda Dishman represents the Northwest CMH Affiliation in a COCE demonstration project involving 3 other PIHP's in Michigan. They are looking at Access standards Screening and Assessment formats. Initial data (Included attachment A) shows an increase in individuals diagnosed with COD up from an initial 8% to 24%. It appears the efforts to identify, diagnose individuals with COD in order to provide stage appropriate treatment has succeeded.

4. **Has a consensus document been developed regarding the overall system change? How widespread is participation within the PIHP/CA system? Submit any documents regarding consensus development, policy direction, and chartering of quality**

improvement activities that have been developed. Identify any overall system priorities that have been adopted (e.g., welcoming, screening, data collection, etc.).

The Northwest CMH and Northern Michigan Substance Abuse Services Regional Charter agreement was submitted with the last quarterly report. The document has not changed. However the COD leadership team will work with the Joint Executive Team to develop and disseminate specific COD expectations for staff. The Joint Executive Team will issue a "position paper" that support the efforts of the IPLT and the COD leadership team. As noted above NLCMH is involved with the COCE demonstration project. The COD Leadership team has a workgroup that is developing Access Guidelines (Attachment B) and a screening tool (attachment C). The screening tool will be piloted from April 16 until June 16 2007. The Access workgroup will revise current clinical assessments to improve the assessment of COD.

5. **Describe participation and involvement during the past quarter of elements of the system that are not part of PIHP/CA service delivery. Include consumer and family stakeholders, primary health care and emergency rooms, criminal justice, homeless services, child welfare, etc.**

The Northwest CMH Affiliation invited local ER doctors and nurses to participate in a breakfast discussion with Dr. Minkoff March 23rd 2007. Dr. Minkoff graciously consented to giving his presentation for videotaping. It is hoped that the lecture can be viewed by ER staff and other medical providers. The COD leadership team has formed another workgroup that will address the COFIT items related to Accessibility. Specifically the workgroup will draft guidelines on when it is appropriate to assess individuals in ER who are identified as having COD and who are intoxicated. This is to address numbers 3, 4 and 5 on the Accessible Domain from the COFIT.

3. There are no arbitrary barriers to initial emergency mental health evaluations based on substance levels.
4. There are no barriers to psychiatric inpatient admission based upon substance levels, substance diagnosis, or need for detoxification and there are no barriers to initial routine mental health evaluation based upon presence of substance disorder and/or length of sobriety
5. There are no barriers to initial routine substance evaluation or treatment based upon psychiatric diagnosis or medication.

The workgroup will initially address #3 and meet with local ER and Emergency Services Team in the Traverse City office. It is anticipated that as this process is formalized it will be introduced to other medical/mental health professionals in the Northwest CMH affiliation. Numbers 4 and 5 will be addressed in the upcoming fiscal year.

6. **Has the system done the CO-FIT 100? If so, describe the process, the score, and what action items are being addressed based on that process? If not, what plans are there to use the tool?**

An updated COFIT was completed in January 2007 (see attached). The COFIT was completed in two sessions by the COD Leadership Team and a workgroup composed of members from the local crisis center and local CA providers. The results were reviewed with Dr. Minkoff on 3/23/07. Action plans are being developed and implemented based on findings. During the first and second quarters, a workgroup was formed to look at the Access and Welcoming domains. This group has produced Access guidelines as well as an access screening tool. A separate workgroup will look at Accessibility Domains. The goal is to develop guidelines for

Emergency Service staff, Hospital ER, and Law Enforcement to follow when working with individuals who have COD and may be intoxicated. The central issue is to provide emergency assessments to individuals with COD in crisis without arbitrary limits imposed by blood alcohol levels based on the driver's license parameters.

7. **How widely has the system implemented the COMPASS? How many programs have done the COMPASS, and how many plan to? Describe the process for doing the tool, collecting the results, and assisting programs in creating quality development and progress for participating programs? What plans are there for widening program participation?**

The COMPASS tool has been utilized by all contract agencies within the CA (NMSAS) boundary. NLCMH Northwest just completed its third Compass and has shown a marked improvement from FY 2005-2006. (See attached). NLCMH SE has completed its first COMPASS. WMCMH has also completed its first COMPASS. The COMPASS has been conducted with participants who are part of the COD leadership team and the clinical leadership team from each agency, The COMPASS is completed in a group setting and consensus is reached on each item prior to moving onto the next item. The results are collected and compiled. They will be analyzed and program objectives will be utilized to assist quality improvement. Dave Branding the QA Manager has compiled the Compass results and has set QA goals for the fiscal year. One of the goals is to collect outcome measures for COD. Joanie Blamer in conjunction with Tom Vinette, Dave Branding Keith Huggett from IT and Joe Garrity modified a data collection form that will be used on a quarterly basis to measure outcome data. The forms mentioned above and following were developed after staff from the Northwest Michigan CMH affiliation traveled to Ohio to observe a mature COD IDDT program. Staff involved found this both illuminating and exciting. One comment was "I have seen the future and we can do this!" Another ongoing QA project is to stage consumers on both Mental Health and COD, who are active clients of the outpatient therapy team, on a quarterly basis. The team will use a form developed by the Ohio SAMI (see attached.) The plan is to continue utilizing the COMPASS on a yearly basis and to use results to develop additional QA measures.

8. **How has the system organized quality improvement activities related to monitoring improvement and integrated services? What are the targets and indicators? Has this been linked with existing PIHP or CA quality improvement activities? How is it connected with consensus priorities listed in question #4 above?**

The Fidelity Review for NLCMH NW will be repeated this FY during the summer. The results of this review will be compared and contrasted with the initial Fidelity Review. In addition NLCMH SE sites and WMCMH sites will have their first Fidelity Review conducted. WMCMHS will schedule a Post-Readiness review with the MI-FAST Team when dates become available for June. The results will be compiled and Quality improvement efforts will be geared towards improving identified performance areas. Currently we are working on implementing outcome data collection for the NLMCH NW office. This form was attached earlier. This will be electronically collected and will be implemented for clients enrolled in the COD –IDDT program as well as during access contacts.

As mentioned last quarter, "The NLCMH QI Plan and Outcome Monitoring Grid were revised at the conclusion of the last fiscal year and approved by the NLCMH Board in December. The grid includes four new measures specific to IDDT including: 1) The percent of IDDT recipients in each stage of change, 2) The percent of IDDT recipients in each stage of treatment, 3) The percent of IDDT recipients in supported employment,

and 4) The percent of adults with mental illness and substance abuse receiving IDDT services. These measures will be reported to the QI committee twice annually and the results will be used along with the findings of on-going self-assessments and fidelity reviews to gauge the level of implementation of IDDT as well as to improve the quality of IDDT services being provided."

9. **What policies and procedures have been articulated or are in process regarding clinical practice development that is universal in the system: welcoming, screening, assessment, treatment planning, stage matching, integrated billing procedures, etc.? Describe the process of development and submit any products.**

The second COFIT was completed in January of 2007. (See attached). The COFIT leadership team has developed two workgroups as mentioned in #6. The workgroups are taking Welcoming and Accessibility and are developing policies and procedures related to these. We hope to be able to report on the progress of the Accessibility Workgroup next quarter. Specifically they will be looking at the issue # 3.

> There are no arbitrary barriers to initial emergency mental health evaluation based on substance levels.

The Welcoming Access workgroup focused on the access guidelines which have been included. It is anticipate that the COD leadership team will continue to develop policies and procedures consistent with the COFIT findings in conjunction with the QA committee. The PIHP polices on welcoming and accessibility were modified last year and have been included in earlier reports.

10. **If you have identified a specific team or teams to implement IDDT, who are they and how were they chosen? Where do they fit in to the larger system's movement toward integrated treatment, and how are they supported by their agencies in this process. Describe how the IDDT teams promote practice improvement in the system as a whole.**

The Co-occurring Disorders (COD) PIHP leadership team (subcommittee of the IPLT), consists of members from the IPLT leadership team and has continued to meet monthly. The team includes members Bill Slavin representing the PIHP, Josh Snyder of West Michigan CMHS, Joe Garrity of NLCMH, and Sue Winter representing Northern Michigan Substance Abuse Services (CA). Joanie Blamer from NLCMH SE has been added to the leadership team. She has instrumental in developing the IDDT-COD programs for the NLCMH SE offices. This group has been empowered by the PIHP (affiliation model), the two CMHSPs, and Northern Michigan Substance Abuse Services (CA) to provide direction to our system transformation efforts across the nine counties.

This group reviewed and resubmitted the block grant carry forward funds. The carry forward request has been approved. The NLMCH Outpatient therapy team has begun staging consumers on a quarterly basis using the stage of treatment format.

We also have continued the COFIT Leadership Team, which recently completed the second annual evaluation of the provider network.

The final two domains of the COFIT Continuity and Comprehensiveness were scored on February 9th and results have been compiled and used to develop an additional workgroup that

is focusing on the Accessibility domain. This workgroup will consult with and work with Local ER and Local Crisis Center to remove barriers to recovery based on SA levels.

11. **What activities are in process regarding IDDT team development? Has the Fidelity Scale been used? Did the PIHP utilize or schedule any Michigan Fidelity Assessment and Support Team (MiFAST) fidelity reviews. What other data collection or performance improvement activities are in process related to the IDDT team? What assistance has been provided by national consultants or others to the team, and what is planned or needed for the coming quarter?**

Linda Dishman represents the Northwest Michigan CMH Affiliation with the MIGHTI work group and is participating in a COCE pilot project. An access screening tool developed by the COFIT workgroup, (Attached) will be piloted from April 16 to June 16 2007. This is instead of the DALI-14 which the access workgroup sees as too limiting and not accurate. The results will be reported to the COCE project and a screening tool will be selected from among all of the pilot projects. The Access workgroup will also look at a Clinical Assessment and may pilot this instead of the ASI-MV as stated last quarter. MiFAST review will be conducted initially in WMCMH and the SE offices of NLCMH. The NW office of NLCMH will schedule a fidelity review this next quarter.

12. **What activities have been undertaken regarding clinical practice development, both in the system as a whole and for staff in proposed IDDT teams? Have clinicians been widely informed of the process of change and trained in basic principles? Have there been efforts to communicate universal goal of dual competency to all clinicians? Have clinician scopes of practice and competencies been drafted or are in process? What training efforts have taken place? Has the use of the CODECAT been considered or initiated? If there are clinical training goals (e.g. assessment, treatment planning, motivational interviewing), what policies or procedures are in place to make it likely that clinicians will be organized and expected to begin to use the training in their work?**

Please see the attached FY 07 workplan and time line. Our plans include the following:

- We plan to continue contracting with Dr. Minkoff and Dr. Cline. They will provide ongoing technical assistance to fully implement the Charter Agreement and assist with systems change. Dr. Minkoff did provide feedback to the leadership team and initial training to staff.

- The Northwest Michigan PIHP will continue to contract with Patrick Boyle of the Ohio SAMI to provide IDDT-COD training to both the NLCMH Northwest and NLCMH Southeast ACT Teams. Patrick will also assist in the Fidelity and GOI reviews.

- The Northwest Michigan CMH Afflation will have staff trained in Supervisory and Implementation Strategies by Dr. David Mee-Lee in May 2007. Dr. Mee-Lee will also conduct a one day workshop on the use of Person Centered planning with individuals identified with COD.

- The Northwest Michigan PIHP team leaders visited ongoing COD-IDDT teams in Columbus Ohio to review effective programs and treatment strategies. The team believes this was a very helpful experience and has shared what they leamed with the COD IDDT teams.

- The Northwest Michigan CMH Affiliation will contract with Heather Flynn PhD to provide advanced motivational interviewing skills to Clinical staff. Dr. Flynn will engage in ongoing supervision using Videotaped sessions. NLCMH has participated in a consortium to bring national speakers on COD to Northern Michigan.

- The Northwest CMH Affiliation will assist in bringing Claudia Black MSW to Northern Michigan. She will present information on Substance Abuse and Depression. This will assist the Northwest Michigan PIHP in facilitating collaboration among Mental Health and Substance Abuse systems.

- The Northwest CMH affiliation plans to participate in the DCH sponsored Motivational Interviewing training of trainers under the direction of Michael Clark. The staff to receive this training have not been selected.

- Josh Snyder developed a set of Clinical competencies that are attached. The IPLT leadership team has adopted these. The Northwest Michigan CMH Affiliation will develop action steps to fully implement these competencies. NLCMH is using the Essential Learning web site www.essentiallearning.net/student to assist in computer based training. One of the courses offered is on COD. Clinical staff will be encouraged to take this course.

- Policies and procedures to assist the clinical staff in using these learned skills have not yet been developed.

13. What administrative barriers from the state have emerged as issues during the last quarter? What efforts have been made to overcome those barriers? What would be helpful at this point from state to address those barriers? What else would be helpful for the state to provide or do to facilitate your progress?

Barriers consist of limited staff times due to expanded case loads and paperwork requirements. The attempt to launch several EBP's at one time seem to conflict and compete with staff time for training, There are a limited number of "experts" available and competing with DCH and other PIHP's for their time creates barriers.

14. What internal administrative or clinical barriers have you encountered in the last quarter, and what efforts have you made to overcome them? What technical assistance have you received in the past quarter? Are there areas where you feel that you could use specific technical assistance and/or training in the future?

Attitudinal barriers still remain, however support from clinicians has begun to emerge. The practice of Staging Consumers seems to assist clinicians in recognizing and incorporating the stages of change in clinical practice. The staging is used for both COD, if present, and for Mental Health change as well. Motivational interviewing is seen as helpful in many areas not just COD.

15. If the project is having problems with implementation/continuation, will all of the allocated resources be needed? Should an amendment be initiated?

The project is not having problems with implementation/continuation. Carry over of unspent funds from FY 2005/2006 were requested and approved. It is unclear yet if all of the funds will be spent, An amendment will be filed when the projected expenditures are finalized.

16. What are the activities and action plans for the next quarter? Describe how project funding is being used in the coming quarter to support the maximum amount of leverage for practice improvement.

The next quarter will be busy from a training and development stand point:

- The Access workgroup is implementing and pilot a screening tool as part of the Mighti COCE project. This group will look at the current Clinical Assessment and may make changes
- A second workgroup will look at Accessibility and establish policies and work procedures for emergency assessments that do not impose arbitrary limits based on level of intoxication
- Claudia Black will present on Depression and Substance Abuse in April.
- Dr. Mee-Lee will present a workshop on the use of person centered planning with individuals diagnosed with COD.
- Dr. Mee-Lee will conduct an intensive 2 day supervision workshop for team leader's/ supervisors working with individuals with COD. This will also occur in May.
- Heather Flynn PHD will provide initial Motivational Interviewing training as well as supervision to those staff that have been trained in motivational interviewing and are implementing the techniques in June.
- Initial MiFAST fidelity reviews will be scheduled for WMCMH and NLMCH SE. A MiFAST fidelity review of NLCMH NW will be scheduled.
- The Northwest Michigan CMH Affiliation will participate in the Michael Clark DCH training of trainers in Motivational Interviewing,
- The IDDT-COD ACT teams will attend the ACT conference in May and attend workshops relating to COD.
- The IPLT and COD leadership team will continue to meet and modify the work plan based on ongoing assessments of progress and need.
- NLCMH will implement an outcome measures pilot study.

17. What actions are being taken by the PIHP to sustain this initiative after the block grant period ends?

Our focus continues to be on developing practice plans to support staff training and training of supervisors to assist in continuing the initiative. The Northwest Michigan CMH Affiliation will pursue additional black grant requests to continue the initiative as appropriate.

Report Completed by: Joe Garrity
Contact Person: Joseph Garrity or in Joe's absence Bill Slavin
Telephone Number: Joe - 231-935-4415 Bill 231– 876-3237

APR 26 2007

Michigan Department of Community Health
Mental Health and Substance Abuse Administration
Improving Practices Infrastructure Development Block Grant
Co-occurring Disorder: Integrated Dual Disorders Treatment
Program Narrative
Quarterly Report

1. Report Period	**Period Ending March 30, 2007 – Report Due Date April 30, 2007 – Second Quarter Report FY 2007**
PIHP	**Saginaw County Community Mental Health Authority**
Program Title	**Improving Practices Infrastructure Development Block Grant – Co-Occurring Disorder: Integrated Dual Disorders Treatment**
Executive Director	**Sandra M. Lindsey, CEO**
Address	**500 Hancock Street, Saginaw, MI 48602-4292**
MDCH Specialist	**Tison Thomas & Patricia Degnan**
PCA#	**20715**
Contract#	**20071291**
Federal ID	**38-3192817**

2. **Briefly summarize the Systems Transformation efforts and implementation activities of the Improving Practices Leadership Team. Describe the activities and actions taken by the IPLT to improve the overall system of care.**

   The SCCMHA Improving Practices Leadership Team continues to provide overall oversight of all evidence-based practice and related recovery efforts at SCCMHA, including COD/IDDT, DBT, ACT, Supported Employment, and FPE. The Improving Practices Leadership Team meets quarterly now, and met on February 15th. The FPE workgroup met twice during the period, and the COD/IDDT workgroup met once (this workgroup meets every other month now) on February 2. The ACT and SE workgroups are charged with conducting fidelity review on a periodic basis and this is reported to the IPLT.

   During this period key staff and providers received additional training, recovery base measurement was initiated at SCCMHA, and key consultants were on site at SCCMHA providing observations, training and consultation to SCCMHA staff and providers.

   Recovery themes are being promoted throughout the service network this year at SCCMHA, to support IPLT priorities as well as the overall SCCMHA mission and vision.

3. **Describe the structure within the PIHP and collaborating CMHSPs and CAs**

that are overseeing the systems change process to support integrated services. Specifically identify leadership team members and state how the the leadership team is empowered by the PIHP, CMHSPs, and CAs to oversee the process. What is the level of participation of the CEOs, Medical Directors, and Clinical Directors of each entity? Where does the IPLT fit into the overall structure of the PIHIP and CA system, and how is it empowered by system leadership?

The work of the IPLT is integrated into the SCCMHA quality program and is reported routinely to the SCCMHA Management and Service Management Teams as well as the SCCMHA Quality Team. IPLT goals are also integrated into the current strategic plan for SCCMHA, which is routinely reviewed by the SCCMHA management team.

The SCCMHA Medical Director has been involved as much as her time has allowed; she has communicated in writing to the network physicians regarding the COD/IDDT agenda with related notices and EBP and COD/IDDT information, and she personally introduced Dr. Minkoff at the evening physician's session held in Saginaw on March 22nd.

Leadership team and specific practice work group members have been identified in previous reports. The CA is represented on both the IPLT and the COD/IDDT workgroup, along with varied substance abuse providers. The SCCMHA Clinical Director continues to serve on the IPLT as well.

4. **Has a consensus document been developed regarding the overall system change? How widespread is participation within the PIHP/CA system? Submit any documents regarding consensus development, policy direction, and chartering of quality improvement activities that have been developed. Identify any overall system priorities that have been adopted (e. g., welcoming, screening, data collection, etc.)**

   Yes, SCCMHA has developed a consensus document; this has been previously submitted to MDCH and has received external endorsement as well locally from varied partners, including the CA advisory board. SCCMHA intends to update this document in the future given some changes in stakeholder representation as well as SCCMHA progress in implementation and the need to include the next wider circle of community stakeholders.

5. **Describe participation and involvement during the past quarter of elements of the system that are not part of the PIHP/CA system. Include consumer and family stakeholders, primary health care and emergency rooms, criminal justice, homeless services, child welfare, etc.**

   Consumers, family members, and a health plan representative serve on the IPLT as well as various work groups for specific practices. It is expected that as the

DDE and DDC providers progress, SCCMHA will embark upon wider stakeholder active involvement with other community partners, such as the court, etc. as mentioned above. An EBP progress update was provided to the SCCMHA Citizen's Advisory Committee in February.

6. **Has the system done the CO-FIT 100? If so, describe the process, the score, and what action items are being addressed based on that process. If not, what plans are there to use the tool?**

   As mentioned previously, a baseline CO-FIT measure was completed. The score was 197-219 out of a possible 300; the range was based on possible interpretations of some items and soft data in some areas upon which to score. There are no current plans to repeat the measurement at this time; the COD workgroup will consider this in the future upon review of the implementation plan.

7. **How widely has the system implemented the COMPASS? How many programs have done the COMPASS, and how many plan to? Describe the process for doing the tool, collecting the results, and assisting programs in creating quality improvement action plans to move toward DDC. What is the status of the action plan development and progress for participating programs? What plans are there for widening program participation?**

   Three of the five DDE programs have completed the COMPASS; the ACT team has completed it more than once.

   SCCMHA plans for continued movement towards DDE status with the case management programs include specific team leader meetings with IPLT leaders. One team has a written implementation plan developed for the program itself, which incorporates not just COD/IDDT, but also FPE and DBT efforts.

8. **How has the system organized quality improvement activities related to monitoring improvement in integrated services? What are the targets and the indicators? Has this been linked with existing PIHP or CA quality improvement activities? How is it connected with consensus priorities listed in question #4 above?**

   SCCMHA is measuring progress by reviewing accomplishments of tasks and goals from the master implementation plan. Recently the key milestones have been captured in a chronological Improving Practices report, attached to this report. Consensus document priorities are included in policy and plan detail. Additionally, SCCMHA clinical leadership meets routinely with the adult case management (DDE) program supervisors, and improving practice updates and information is a standing agenda item for those monthly meetings.

9. **What policies and procedures have been articulated or are in the process regarding clinical practice development that is universal in the system:**

welcoming, screening, assessment, treatment planning, stage matching, integrated billing procedures, etc.? Describe the process of development and submit any products.

Integrated assessment has been included in the new electronic medical record at SCCMHA for these programs; stage wise additions are being pursued for the progress documentation as well as person-centered planning. A welcoming policy has been drafted. All other policies were completed earlier in early implementation phases of the project. Coding information has been disseminated to the teams, although implementation of coding is subject to the external review and MDCH approval.

10. **If you have identified a specific team or teams to implement IDDT, who are they and how were they chosen? Where do they fit into the larger system's movement towards integrated treatment, and how are they supported by their agencies in this process? Describe how the IDDT teams promote practice improvements in the system as a whole.**

SCCMHA remains committed to having all adult case management programs serving adults with serious mental illness being dual diagnosis enhanced. There are four case management teams and one ACT team in the SCCMHA network. All other key programs that serve this population, as well as programs that serve other populations and the substance abuse provider network members, are expected to be dual diagnosis capable.

11. **What activities are in process regarding IDDT team development? Has the Fidelity Scale been used? Did the PIHP utilize or schedule any Michigan Fidelity Assessment and Support Team (MI-FAST) fidelity reviews? What other data collection or performance improvement activities are in process related to the IDDT team? What assistance has been provided by national consultants or others to the team, and what is planned or needed for the coming quarter?**

During this quarter Kenneth Minkoff provided a day long consultation at SCCMHA; on March 22nd, he provided two DDE team consults (a total of 19 persons attended), an administrative staff lunch consultation, a general overview session in the afternoon for 36 participants, and an evening session for 5 network psychiatrists. The latter event was significant, although SCCMHA has provided input to key physicians, this was the first direct consultant contact with this group on the practice. Dr. Minkoff was very well received by each audience, and he provided valuable insight and observations on SCCMHA progress to all levels of staff. There was administrative discussion with him about his return later this year or early in FY 08 to meet with community partners, such as court staff.

Dr. Minkoff felt that SCCMHA was making good progress, emphasizing that true implementation of this practice takes multiple years. He emphasized the

'relationship' of the client and case manager, not to get lost in the practice implementation tasks.

Also during this quarter, training by Michael Clark was initiated on sight at SCCMHA as previously scheduled, in the areas of substance abuse counseling, and stage wise interventions. He was on site for three full days providing training to case management and other clinical and supervisor staff from the DDE programs that are implementing COD/IDDT services.
SCCMHA requested a fidelity schedule change from April to August, but has not heard on scheduling at this time.

12. **What activities have been undertaken regarding clinical practice development, both in the system as a whole and for staff in proposed IDDT teams? Have clinicians been widely informed of the process of change and trained in basic principles? Have there been efforts to communicate universal goal of dual competency to all clinicians? Have clinical scopes of practice and core competencies been drafted are in process? What training efforts have taken place? Has the use of the CODECAT been considered or initiated? If there are clinical training goals (e.g. assessment, treatment planning, motivational interviewing), what policies or procedures are in place to make it likely that clinicians will be organized and expected to begin to use the training in their work?**

There is continued system emphasis to clinicians of the practice expectations and training requirements now embedded in SCCMHA policy, and supervisory support and reinforcement is actively occurring. Dual practice discussion is occurring in team and staff meetings at the program level. Ongoing training, resource information and planning discussions are occurring at team, program and management levels.

13. **What administrative barriers from the state have emerged as issues during the last quarter? What efforts have been made to overcome those barriers? What would be helpful at this point from the state to address those barriers? What else would be helpful for the state to provide or do to facilitate your progress?**

Due to time constraints and multiple role responsibilities of SCCMHA leadership staff assigned to COD/IDDT as well as other EBP implementation tasks, regular attendance at all state meetings has been a challenge. SCCMHA recommends MDCH consider changing the frequency of state meetings from monthly, and supports MDCH current examination of state support efforts. At times the SCCMHA priority must be to attend to internal oversight of local practice implementation rather than attend state meetings.

14. **What internal administrative or clinical barriers have you encountered in the last quarter, and what efforts have you made to overcome them? What**

technical assistance have you received in the past quarter? Are there areas where you feel that you could use specific technical assistance and/or training in the future?

Potential barriers continue to be clinician time demands and administrative oversight resources. No specific technical assistance needs have been identified at this time.

15. **If the project is having problems with implementation/continuation, will all of the allocated resources be needed? Should an amendment be initiated?**

It is expected that all allocated resources will be needed at this time.

16. **What are the activities and action plans for the next quarter? Describe how project funding is being used in the coming quarter to support maximum amount of leverage for practice improvement?**

The IPLT will assess progress using the General Organizational Scale in May. Continued targeted training with Michael Clark will occur as well. IPLT leadership will be meeting with each of the DDE team leaders and team champions to review progress, barriers, successes, etc. this quarter as well.

17. **What actions are being taken by the PIHIP to sustain this initiative after the block grant period ends?**

Policy and procedure integration, electronic medical record installation that includes integrated treatment formats, and supervisory and administrative oversight of practice implementation, as developed and to be refined as needed, will support sustainability.

Contact Person	**Ginny Reed, Director of Network Services & Public Policy – Improving Practices Leadership Team Facilitator**
Phone	**989-797-3493**
Fax	**989-799-0206**
E Mail	**greed@sccmha.org**

COD - Initiative
Quarterly Narrative Report
2nd Quarter
FY 2007 January 1, 2007 – March 31, 2007

1. COD Initiative
PCA #06-20716
Contract: #20071342
2nd Quarter / FY 2007 January 1, 2007 through March 31, 2007
Karen Cashen

2. The Thumb Alliance PIHP's Improving Practices Leadership Council (IPLC) continues to provide system level oversight to the IDDT tool kit implementation process. As regional action planning in response to the IDDT baseline fidelity assessment progresses, the IPLC anticipates the need to address region wide barriers to increased model adherence and will act as a conduit to the Thumb Alliance

In addition, the IPLC has begun to oversee additional key clinical practices. The Thumb Alliance has now formally endorsed the creation of a regional Recovery Workgroup to provide direction to the system as we move towards the creation of a true Recovery focused environment. The Lapeer CMHSP has also begun to undertake implementation of the Family Psych-Education Tool Kit, and is reporting on the progress of that endeavor to the IPLC. The IPLC is also evaluating potential additional EBPs for system-wide implementation.

3. The Thumb Alliance PIHP is working towards formal integration of the public mental health and substance use systems concurrent to the efforts to implement the IDDT tool kit. Both the PIHP Board, and the governing St. Clair County CMH Board have endorsed the movement of St. Clair County CMH towards formal designation as the regional Coordinating Agency. The necessary formal waiver requests and request for designation as the regional CA have been approved by both boards and have been approved by MDCH as well. The Thumb Alliance PIHP will be designated as the regional CA effective 10/1/07. The Thumb Alliance Management Council has taken leadership in the CA transition activities, with all three CMHSP Directors (who are standing members of the Management Council) taking lead with their local county Board of Commissioners to ensure appropriate education and to request endorsement. The Management Council has formed, via the PIHP a CA Transition Workgroup to implement the transition plan. The Chief Operating Officer (COO) of the PIHP chairs that group, which also consists of the current CA Director, the PIHP Chief Clinical Officer (CCO), and key administrative leadership staff in the areas of IS, QI, Data Management, Fiscal, and Contract Management. In addition, lead PIHP staff have been meeting with staff from ODCP to prepare for a successful transition.

There is significant crossover between that group and the two primary groups related to the implementation of the IDDT Tool Kit (the IPLC and its sub work group, the Co-Occurring Disorders Workgroup). The IPLC is chaired by the PIHP Medical Director. The COO and CCO of the PIHP are members of both the IPLC and the COD Workgroup, as is the CA Director and the QI/Data Management Director from the PIHP. Clinical Leadership representatives from the three Thumb Alliance CSSNs are also members of both the IPLC and the COD Workgroup. All of these groups report to the Thumb Alliance PIHP Management Council.

4. The Thumb Alliance PIHP has developed and previously submitted two documents related to system transformation. The Thumb Alliance revised its Vision statement in the last fiscal year to better capture its goals and efforts towards system transformation. In addition, the Management Council and the applicable Boards endorsed a Charter document created by the IPLC to guide its efforts in the system transformation process.

   The Thumb Alliance PIHP has not as yet created formal consensus agreement documents with the provider network system.

   Welcoming and Integrated Screening are two topics that are currently being addressed by the PIHP within the IPLC construct. The PIHP has revised its system wide policy on access to ensure it is appropriate to all populations we serve. Among the changes made is the incorporation of the concept of welcoming throughout the process. We are also currently working with Wayne State University and participating with the COCE project to explore the concept of integrated and standardized screening throughout the Thumb Alliance region.

5. Much of the energy over this past quarter was directed at responding to the results of our baseline IDDT/GOI fidelity assessment process via the development of local action planning teams. We have not had high level involvement of those systems external to the PIHP/CA system throughout this quarter. Higher level involvement is anticipated as we begin to flesh out action plans and continue down the road to formal system integration, however.

6. The Thumb Alliance PIHP did complete the CO-FIT 100 last fiscal year. We administered the CO-FIT 100 to a group that included our Management Council as well as our IPLC. As a region, we scored 154/500 on the CO-FIT 100. As we analyzed the results of that process, we struggled to be able to use the results for the development of a work plan with any specific tasks. The tool and resulting data was too global and general, in our opinion. As we consulted with Wayne State University regarding our results and next steps, we made the decision to move ahead with the IDDT/GOI baseline evaluations and to table use of the CO-FIT 100 for future discussion should the IDDT/GOI process not yield positive outcomes for the system.

7. We have not implemented the COMPASS to date. We are focusing on the IDDT/GOI fidelity assessment process at this time.

8. The Thumb Alliance PIHP has begun to organize QI activities related to this initiative. Under the leadership of our QI/Data Management Division, we have shown significant improvements in our conscientious reporting of demographic data describing the prevalence of COD within the public mental health SMI population. We have also begun work revising policies to reflect necessary system attention to co-occurring disorders, including our access policy and our credentialing and privileging policy. We have formed a sub-group to evaluate our screening protocol and process (both at the front door and within the treatment continuum) and will examine the potential benefits of using standardized integrated tools throughout the system.

   The Thumb Alliance PIHP has also developed an aggressive training protocol related to system competency to treat individuals with COD. We are midway through a yearlong plan involving Wayne State University that provides us with training in the areas of:

   - Understanding IDDT;
   - Motivational Interviewing – including formal training, coaching, and scoring of taped sessions;
   - Stage-Wise Intervention;
   - Pharmacology and COD for medical and non-medical providers;
   - Understanding Addiction;
   - Screening, Assessment, Diagnosis, of SUD in the SMI Population; and,
   - Clinical Treatment of SUD for individuals with SMI.

   The Thumb Alliance is working with WSU to make available CEUs and CMEs for as many courses as possible in this curriculum.

   The feedback we have received from staff related to these trainings has been overwhelmingly positive. We are working with Wayne State University to create training modules in some of these areas for future use as introductory or refresher trainings.

9. The Thumb Alliance PIHP has revised its policies on Access and Credentialing and Privileging. We anticipate more significant policy development and revision to needs to be articulated via the local action planning processes that are now being initiated in response to our baseline IDDT/GOI fidelity assessment process. The process we use for these initiatives will likely vary based upon the type of policy that requires either revision or development. All recommendations and actions in this area will come via the regional COD workgroup.

10. We have just begun this process with the wrap up of our baseline IDDT/GOI fidelity assessment. Each CSSN has formed a local action plan development team with representation from the direct service providers (including peer support staff), key agency decision makers, agency QI staff, and program leadership staff.

These groups have begun to take lead in developing and implementing local action strategies regarding IDDT implementation. The initial draft plans have been shared at the COD Workgroup level. The COD workgroup is serving as a consultative body in this process, allowing for sharing of ideas and resources, and promoting consistency in how we understand results of the assessments and move forward towards increased adherence to the model.

11. See above in regards to activities underway. Our baseline IDDT/GOI fidelity assessment was completed in the first quarter of this fiscal year. We have been contracting with WSU from the outset on this process. The Thumb Alliance PIHP opted to create its own team and contract with WSU for leadership and consultation. Our team was co-lead by an experienced WSU evaluator and our clinical analyst, a PhD. Psychologist who has received training in this process via Patrick Boyle (training and shadowing) and WSU. Our team included primarily PIHP staff. One unique quality of our evaluation team relative to MI-FAST and other evaluation teams we have seen/heard about, is that the Thumb Alliance PIHP elected, from the onset, to include a peer support staff as a full member of the evaluation team. We believe this has allowed us to look at our regional programs and policies with a more complete perspective and has definitely added value to the process. The IPLC recently reconsidered the option of formally joining the MI-FAST group relative to the evaluation process but elected (unanimously) to continue with our established process for a variety of reasons.

    The Thumb Alliance has been represented at training and consultation provided by Patrick Boyle, as well as the Minkoff/Cline trainings. In addition, we have had a staff member shadow one of Patrick Boyle's review teams in Ohio, we have contracted separately for IDDT/GOI training from WSU, and we have participated with MI-FAST (except for the fact that we are not actually receiving or providing evaluation services via that group).

12. We have not used the CODECAT system wide to date. As we referenced earlier, however, we have initiated an aggressive training protocol this fiscal year that targets a wide variety of staff. Among the objectives of this protocol are to increase the system level awareness of our transformation efforts related to IDDT, to increase the understanding of the IDDT tool kit, and to increase staff knowledge and competency in the identification and treatment of co-occurring disorders.

    In addition, the IPLC has, within its current QI plan, identified review and revision of the PIHP clinical protocols as a current targeted task.

13. The Thumb Alliance has not identified any new barriers this quarter. The barriers identified previously still seem to exist, however, including but not limited to:
    - Lack of integration between the Mental Health and SUD bureaus of MDCH, which seems to cause an inability to make decisions/policy calls that may impact both the MH and SUD systems expediently at the state level;

- Differences in policies/rules/practices related to confidentiality, recipient rights, ability to pay, etc.;
- The use of language in licensing rules that causes provider level confusion regarding licensed integrated treatment and the IDDT tool kit implementation; and,
- Need for clarification around the use of selected service code modifiers that will be used to more readily track services provided to individuals within programs that are licensed integrated treatment programs, in addition to those with that licensure that are also implementing the IDDT tool kit (to more easily tie programming and fidelity levels to specific consumer outcomes).

14. The Thumb Alliance has not encountered any new barriers over this second quarter. We anticipate that the ongoing development of local action plans will bring local and regional implementation barriers to the surface.

15. We have submitted an amendment with a request to carry forward funds from year one. This need was primarily caused by the baseline fidelity assessment process needing to be continued into the beginning of this fiscal year and our agreement to reimburse WSU for their assistance with this process at the point of completion.

16. The primary activities for this coming quarter are in the areas of local action plan development, policy revision and development (including exploration of the use of standardized integrated screening tools), staff training and curriculum development (in consultation with WSU), and continued participation with state level efforts related to system transformation. The Thumb Alliance PIHP CCO is involved in all of these efforts and we will continue to access WSU for consultation and assistance in the implementation process.

17. The Thumb Alliance created the IPLC with the intent of continuing system transformation efforts beyond the terms of the block grant. It is a group and function that has become embedded within the PIHP structure. In addition, the PIHP is working towards creating training modules based upon the curriculum developed with WSU that will be used as refresher material for existing staff and as orientation/training material for future new staff. The training modules will be placed in our online library and will be updated as necessary.

Jim Johnson, Chief Clinical Officer
810-966-3582